# LONG-TERM CARE

# HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

MARCH 31, 1987

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# LONG-TERM CARE

## TUESDAY, MARCH 31, 1987

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 9:45 a.m., in room 1100 Longworth House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
MONDAY, MARCH 23, 1987

PRESS RELEASE #8
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.),
CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON
LONG TERM CARE
TO BE HELD ON TUESDAY, MARCH 31, 1987

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The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced a hearing on the issue of long term care. The hearing will be held on Tuesday, March 31, 1987, beginning at 9:30 a.m., in room 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark stated, "The Subcommittee's recent hearings on providing catastrophic coverage under Medicare has raised a number of questions about the need to expand the program's chronic care benefits. Increases in the number of our elderly citizens combined with large and increasing out-of-pocket expenditures for long term care has generated renewed concern about the financing and delivery of these services."

The Subcommittee hearing will focus on defining the major issues in long term care. Witnesses will provide testimony on the projected need for these services and the problems of the existing financing and delivery systems. Options for financing long term care will be presented, including expanded Medicare benefits, home equity conversions, and private long term care insurance. The hearing will also allow provider representatives an opportunity to present their views.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

## BACKGROUND

The phrase "long term care" refers to a wide array of medical, social, personal, and specialized housing services needed by individuals. The range of chronic illnesses and conditions resulting in the need for supportive long term care services is extensive. Although chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. These conditions may include heart disease, stroke, arthritis, and dementia.

Expenditures for long term care are an increasing burden for senior citizens, as well as a strain on the resources of public programs. Total national nursing home expenditures reached $35.2 billion in 1985, of which $16.5 billion was financed by public programs and $18.7 billion by private sources. Less than 2% of the private expenses were financed by insurance with the balance paid directly out-of-pocket by the consumer.

The Medicare program accounts for only a small portion of the nation's expenditures for nursing home care. Medicare expenditures for nursing home care in 1985 amounted to $600 million, representing 2% of total national spending and 3.6% of public spending. Medicaid contributed $14.7 billion, 42% of total national spending and 89% of public spending.

Medicare has historically not been regarded as a program intended to support long term care as the program's coverage has always focussed on acute care. Program coverage of nursing home care is now limited to 100 days of skilled nursing facility services following a hospital stay of at least three consecutive days.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, April 24, 1987, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS

*****

Chairman STARK. The Health Subcommittee of the Committee on Ways and Means will come to order. Today we will focus our hearing on catastrophic health care costs associated with long-term care.

The long-term care financing system has been characterized as the most frustrating issue in health policy today. The present system satisfies no one. Nevertheless, our concern for the problems created by the existing long-term care financing must be tempered by the budget realities and the administrative complexities which confront us.

We need to identify the steps necessary to improve the long-term care financing system, and we need to be open to new ideas and new approaches which will help us solve our problems, even if we cannot find a solution in this Congress.

We need to keep specific issues in mind: the changing demographics assured the need for long-term care and its costs will increase; virtually all Americans lack insurance protection—either public or private—to protect against any catastrophic costs associated with long-term care.

However, long-term care policy development is complicated by a number of difficulties, and those dictate a cautious approach. Only a third of those potentially at risk for nursing home care now reside in a nursing home. The remainder are cared for at home, the majority by their families. If, in fact, we were to provide financing, one could presume that at least the population in long-term care facilities would double immediately. Creating that kind of incentive for the use of scarce resources may be beyond our ability.

Today's elderly, as a group, are better off financially than their parents, and a small portion of them will improve their financial situation further over the next 15 years. However, without any major changes in our public assistance policies, there is no indication that the majority of our seniors will rise much above the poverty level.

A limited number of lending institutions across the country have begun to offer home equity conversions, and these vehicles provide a mechanism to change equity into liquid resources which could be used to meet some of the costs of long-term care.

It is interesting to note that while two-thirds of the elderly could be considered middle or low income by our standards, the reverse is true and two-thirds, or almost 70 percent of the seniors own their own homes. Whether in this broad data there exists some area for us to find financial assistance is something we should explore.

I hope that today's witnesses will assist the subcommittee in better understanding the dimensions of the problem and will contribute their best judgment about how to begin addressing it. I also will hope that if they have read with rapture my long opening statement, which they will notice I have just paraphrased and will ask unanimous consent to put in the record in its entirety, that our witnesses will take a key and pick out the salient points of their testimony, expand on it extemporaneously, and enlighten and delight us in whatever manner they see fit.

[Chairman Stark's opening statement follows:]

## OPENING STATEMENT OF THE HONORABLE FORTNEY H. (PETE) STARK

Today, the Subcommittee continues its series of hearings on catastrophic health care costs, specifically those costs associated with long-term care.

The long-term care financing system has been characterized as the most frustrating issue in health policy today. The present system satisfies no one. Nevertheless, we are confronted with problems created by the budget realities and administrative complexities.

We do need to begin moving forward to identify the steps necessary to improve the long-term care financing system. We need to be open to new ideas and new approaches which will help to get us out of the box in which we find ourselves, even if we cannot move forward aggressively at the present time.

In so doing we need to keep a number of specific issues in mind:

The aging of our society assures that the need for long-term care—and its costs—will increase.

The long-term care delivery system continues to rely upon institutional care as community resources such as home care have not yet developed to their full potential.

Virtually all Americans lack insurance protection—both public and private—against the catastrophic costs associated with long-term care.

Dominance of long-term care costs within the Medicaid program is interferring with Medicaid's ability to serve the non-elderly poor.

However, long-term care policy development is complicated by a number of difficulties, which dictate a cautious approach.

Only one-third of those potentially at risk for nursing home care now reside in a nursing home—the remainder are cared for at home, the majority by their families. Financial support for long-term care could produce a disincentive for families to care for individuals capable of remaining at home. Creating such a disincentive is the last thing we would want to do.

Long-term care services run the gamut from homemaker services to highly skilled professional medical services. Defining a benefit package within this range is not an easy task.

Today's elderly, as a group, are significantly better off financially than their parents, and are expected to improve their financial situation even further over the next twenty-five years.

These income gains are modest and in no way adequate to meet the extraordinary cost associated with long-term care. Research suggests that many of the elderly could respond financially to a need for long-term care if insurance was widely available to allow the relatively modest individual risk to be spread. This is a subject which demands further exploration.

In addition, older persons are often owners of homes which are mortgage-free. A limited number of lending institutions across the country have begun to offer home equity conversions. These vehicles provide a mechanism to change equity into liquid resources which could be used to meet some of the cost of long-term care.

We also should explore new approaches to public financing of long-term care. Medicare remains the cornerstone of our national commitment to providing adequate health care for 27 million elderly and more than 3 million disabled. Yet changes in demographics and changes in medical practice may require a change in Medicare's basic focus on acute care.

Changing the balance between acute and chronic care requires careful analysis and thoughtful consideration. We should not proceed precipitously.

I hope that today's witnesses will assist the Subcommittee in better understanding the dimensions of the problem and will contribute their best judgement about how to begin addressing it.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Mr. Chairman, you covered things thoroughly and well. I would only want to use this opportunity to thank you for scheduling this hearing. The focus, in part as a result of the bill which we jointly introduced with many of our colleagues, is on elderly acute catastrophic care, but the discussions which have taken place in Subcommittee and elsewhere have brought forcefully not only to us, but to the public, the much larger problem of long-term care. I am delighted we will have a chance to address it with such excellent witnesses this morning.

Thank you, Mr. Chairman.

Chairman **Stark**. Our first witness is Dr. Bruce Vladeck, president of the United Hospital Fund of New York. Bruce, welcome back to the committee. Proceed in any manner you are comfortable.

## STATEMENT OF BRUCE C. VLADECK, PH.D., PRESIDENT, UNITED HOSPITAL FUND OF NEW YORK

Mr. **Vladeck**. Thank you very much, Mr. Chairman and members of the committee.

I want to express my appreciation for being invited here today, not only because it is an honor to be invited to such a hearing, but particularly because, as someone who has been engaged in one way or another in long-term care issues through the last decade or so, it is especially heartening that you are having this hearing on this subject.

For a number of years, in this city and throughout the country, there was sort of a gentleman's agreement that you did not talk about long-term care in polite circles because of its potential budgetary or programmatic implications. I am glad it is on the agenda, even in a first look, incremental sort of way.

I would like to make five points this morning. I have a prepared statement which can be read or disposed of at one's leisure, but I would like very briefly to make five points that are contained there.

First, while the conventional wisdom has been for a long time that long-term care is, in a sense, not Medicare's problem because Medicare covers so little in the way of long-term care services and because such a small fraction of Medicare expenditures are for long-term care services, in fact Medicare is much more deeply implicated in long-term care than is generally realized; and the long-term health of the Medicare program itself depends to a considerable extent on long-term care policy.

Second, there is much to be said for a variety of private mechanisms that are being discussed to improve the use of private resources to finance long-term care. They will not, I do not think, solve our problem of public financing.

Third, I think it is possible within the scope, the spectrum, of long-term care services to define relatively narrowly a set of services by medical criteria, or by medical and professional criteria, that one could cover under the Medicare program without opening a slippery slope for all sorts of custodial and home care services.

Fourth, I think the logical place to begin is with the existing Medicare skilled nursing facility and home care benefits, both of which have been substantially eroded, and both of which can be significantly improved.

And, fifth, I think there are a number of longer term issues having to do with the financing of long-term care services for which there is no one best answer, for which no one has the magic prescription. But I believe there are short-term incremental things we ought to be doing to begin exploring those longer term financing mechanisms more carefully.

Let me say a little bit about each of those points very quickly, if I may. On the issue of Medicare, we know that roughly only 3 percent of Medicare expenditures now go for skilled nursing facility and home health services. Clearly, the program was designed at the outset to limit its liability for conventional nursing home or long-term services.

However, more then 10 percent of Medicare beneficiaries pass through formal long-term care systems in any given year. People in long-term care in nursing homes and long-term home care use an awful lot of part A hospital services, an awful lot of part A outpatient services, an awful lot of physician services, and so forth.

Before PPS we used to estimate regularly that 5 to 7 percent of Medicare inpatient acute days were spent by patients on alternate care status, awaiting nursing home placement or, less frequently, home care placement. Either those patients have disappeared since PPS into what Carroll Estes has called the no care zone, or, in fact, they are still there. HCFA says they are still in the base. We are still paying, according to HCFA, that 5 or 7 percent add-on, as it were, for patients in transition to the long-term care system in our acute hospital payment. We no longer have any reason to collect data on it, and we do not. But a lot of the folks passing through what we think of as the acute system are long-term care clients.

We know that the more efficacious the long-term care system, the less its clients use acute services—use rehospitalizations, use emergency rooms, and so forth. So there are direct fiscal implications for Medicare in terms of improvements in long-term care, as well as the recognition that for folks who are already identified as long term care clients—all of whom are Medicare beneficiaries—Medicare is now spending a lot of money on them that it does not categorize as long-term care, but as part of the acute benefit.

Further, I think you can make the case—and I know, Mr. Chairman, that you have been particularly concerned—that Medicare is more than merely a way of passing money from one hand to another. There are some responsibilities in the program for the well-being of beneficiaries. Given the impact of these services on beneficiaries, and the fact that the boundaries we now draw between Medicare and Medicaid can create so much distress, it seems to me, at a minimum, necessary to pay attention to what the existing program does to its beneficiaries who need long-term care.

Second, on the issue of private financing, you will be hearing a lot about that, for a lot of understandable reasons. I myself think anything that can pass a market test with appropriate consumer safeguards ought to be tested and ought to be tried. There is no reason not to do it. But I think it is important to recognize that the majority of the dollars already in the long-term care system are private dollars, and that what most of the proposed financing mechanisms do is not so much generate new dollars as convert the liquidation of assets at the end of life into a longer term premium payment or use of equity. I think that is fine for those who want it, but it does not solve our public financing problem.

Some of the elderly are significantly more affluent than in the past, but those are not the folks most at risk for long-term care services. The typical person entering the long-term care system is an 80-year-old widow whose primary source of income is Social Security, who does not have private pension kind of coverage, who has probably outlived familial assets, and who is receiving a lot of nonmarket care from family members. There are not a lot of dollars, I do not believe, to be tapped there.

The real distributive issue in financing long-term care, it seems to me, starting from where we are now, is the split of responsibility between the States and the Federal Government, or between the Medicaid program and the Medicare program. I know that just raising that issue raises a whole host of complications of all sorts, but I do not think in the long term we will ever resolve these issues without addressing the relationship between titles 18 and 19 in a more coherent way.

Third, it is true that for most folks who are in long-term care, most of the services they need are not highly professional in content; they have a lot to do with assistance in activities of daily living, with normal companionship and so forth. Nonetheless, I think it is important to recognize that most long-term care clients are seriously ill. That is why they are such heavy users of part A and B services; they have a number of medical care needs, many of which fall between the cracks when they are identified as being in the long-term care system.

It is a little hard for me to understand why we should pay for rehabilitative nursing under Medicare if the community has a facility that, under the quirks of our current classification system, is a PPS-exempt rehabilitation distinct part, and yet not, in many instances, pay for the same nursing service if the patient is at home and does not meet some of the other criteria for Medicare home care.

It is not entirely clear to me why we should pay for a nurse to help in the administration of drugs when the patient is in a hospital or in a Medicare-certified skilled nursing facility bed and not when the patient is domiciled elsewhere.

Again, I believe one could make a list, depending on one's professional biases and budgetary constraints, of which medical services needed by Medicare beneficiaries outside of hospitals might appropriately be covered by Medicare more generously than is now the case.

I also think we ought to start with the existing benefits. My own hobbyhorse in this regard, and I know you will have witnesses later today who know a lot more about home care than I do, is the skilled nursing facility benefit. I think what the Congress did in 1965 in creating the extended care benefit was correct. We just did not have either the expertise or the demographics to support that volume of services then.

The kind of service I mean is postacute, with an average length of stay of probably no more than 30 days, a typical length of stay probably closer to 20 days, for patients who were discharged from the extended care facility home with minimal postdischarge services thereafter.

We have had one demonstration of that that has been quite successful: the rural swing bed experiment, where average lengths of stay are 20 days or so. The HCFA evaluations show that, net, swing beds are a cost-effective service. There is a high level of client satisfaction; quality is reasonably adequate. It is time to re-look at that entire benefit as the number of beneficiaries has changed, as beneficiaries have aged, as we have shortened acute stays, and so on.

Again, it is a medically coherent connection to the acute episode and, therefore, I think fits with Medicare. You can make some of the same arguments about home care. I will defer on that to the real experts.

Finally, let me say that we now have a system in long-term care that is paid to a slight extent by Medicare, to a greater extent by Medicaid, both State and Federal, other public funds including the Older Americans Act, state appropriations and so forth, and a considerable proportion of private resources.

If you take the position that Medicare has been getting off the hook in terms of some of its responsibilities and ought to play a more direct role, there are literally an infinite number of ways you could do that. I think the most important thing in the short-term is to begin to think about, address, and explore some of these issues.

In that regard, we had a lot of experimentation in Medicare through both appropriations and, more importantly, the use of the waiver authorities, in the early 1980's. I do not know quite how you legislate that, but there are a lot of things we ought to be trying. There are a lot of things in the pipeline that ought to be tested. That activity has ground to a halt over the last 2 or 3 years, and over the long-term, the best investment we could make would be to put $25 million or so in appropriated funds plus expanded waiver authority and test a variety of different sorts of mechanisms for financing long-term care in different sorts of communities.

I very much appreciate the chance to express these views. I would be delighted to answer any questions you might have.

[The prepared statement follows:]

# Statement

by

Bruce C. Vladeck
President
United Hospital Fund of New York

Mr. Chairman, members of the committee, my name is Bruce C. Vladeck. I am President of the United Hospital Fund of New York, a research and philanthropic organization. I have been involved for most of the last decade, in one way or another, in issues of long-term care and long-term care policy.

I very much appreciate the opportunity to appear before you today. I am flattered by being asked to testify. And I am particularly delighted by the subject of today's hearing. For the last several years, there has been a kind of conspiracy of silence about long-term care within the federal government's policymaking process. The significance of long-term care issues has been widely acknowledged, but fears of the fiscal and programmatic implications of any possible federal initiative have created a climate in which long-term care financing was not discussed for the record in polite company.

Thanks in part to Secretary Bowen's initiative, the issue of how to assure that America's elderly citizens get long-term care services when they need them, and the concomitant issue of how payment for those services should be rationalized, is now irreversibly on the table, where it will remain until we devise better policies than the unsatisfactory fragments of conflicting and often incomplete programs that have evolved over the last two decades.

I would like to take the opportunity you have afforded me today to make five fundamental points about long-term care, which I hope you would keep under consideration as you address these issues this year and in the future. My points might be summarized as follows:

- First, Medicare is already implicated in long-term care financing, as well as service delivery, to a much greater extent than is generally realized;
- Second, while private resources will continue to provide a major source of long-term care financing, private sector incentives cannot, by themselves, come anywhere close to providing adequate financing for all persons who need formal long-term care services;
- Third, while there is a certain seamlessness to the needs of long-term care clients, and while it is desirable to meet their needs through integrated service systems, it is possible to define a specific set of distinctly medical services needed by those clients, and as the primary provider of insurance against medical expenses for the elderly, it is appropriate that Medicare pay its fair share;
- Fourth, the logical place to start is with existing Medicare benefits, which should be modernized to reflect increased knowledge and changes in the Medicare population;
- Fifth, there is no significant conceptual difficulty in describing either a defined set of benefits or an appropriate set of financing mechanisms for more rational and constructive Medicare long-term care policy.

Medicare's Role in Long-Term Care

Most discussions of long-term care financing, at least those that take place in Washington, begin with the assumption that Medicare's role in long-term care is and should continue to be very limited. It is certainly true that the framers of the original Medicare legislation sought to limit the program's liability for traditional long-term care services, and it is also true that less than 3% of total Medicare expenditures now go for skilled nursing facility and home health care services, the only covered services commonly thought to involve long-term care as such. Most public financing for long-term care is provided by Medicaid.

In fact, however, Medicare already has a far larger financial stake in long-term care than is generally realized. More than 10% of aged Medicare beneficiaries use at least some long-term care services in any given year, and while the majority of those nursing home days or home care visits are not paid for by Medicare, other services received by those clients while in long-term care are, most notably including physician visits. Long-term care patients are also notably heavy users of acute inpatient and outpatient services, and a range of Part B services, which are paid by Medicare, but which existing data systems don't distinguish from use of similar services by otherwise healthy beneficiaries experiencing acute medical episodes.

Perhaps most dramatically, in the days immediately before the initiation of the Prospective Payment System (PPS), it was variously estimated that anywhere from 5% to 10% of all Medicare acute patient days were spent by patients on alternate care status; that is, patients who had been medically determined to need post-hospital long-term care services, and no longer need acute care, but who remained in acute hospitals waiting placement in appropriate long-term care settings. Since the advent of PPS, the Health Care Financing Administration has refused to consider additional payments for non-outlier alternate care patients, on the grounds that the cost of those services, as they were provided in the PPS base year of 1981, are already incorporated into both the PPS standardized amounts and the relative case mix weights. If HCFA is correct in that assertion, and I believe it is, then in other words some fraction of every PPS inpatient hospital payment reflects the historical costs of caring for long-term care patients in transit between the acute and long-term care systems. We have no information, and in fact no longer have any incentive to collect information, on the extent of the alternate care phenomenon in the post-PPS environment. We do know from the General Accounting Office that, post-PPS, there is substantially greater demand for both post-hospital nursing home and home care services, without concomitantly large increase in supply. We don't know, in a systematic way, whether those two phenomena result in increased amounts of alternate care, or instead in increased numbers of would-be alternate care patients discharged home into what Professor Carroll Estes has called the "no care zone," but in any event, Medicare's immediate financial, not to say programmatic stake, is very large.

In the past, I have estimated that as much as 10% of total Medicare expenditures in New York State - the state with the most generous system of Medicaid financing for long-term care - were made on behalf of beneficiaries formally involved in the long-term care system, either as nursing home residents or clients of community-based long-term care programs. As noted earlier, the data are notoriously spotty, but given less generous Medicaid programs and higher rates of nursing home utilization in most of the rest of the nation, that figure is probably conservative for the nation as a whole. We do know, from other data sources, that the 15% of Medicare beneficiaries who are dually eligible for Medicaid account for more than one-third of total Medicare expenditures. Many of those people are low income non-institutionalized elderly and disabled, but a considerable fraction are the nursing home residents who have "spent down" to Medicaid eligibility, but who, of course, remain entitled to Medicare benefits for inpatient hospitalization, physicians' visits, and so forth.

Medicare also has a significant indirect financial stake in long-term care. Effective, high-quality long-term care services, whether provided in nursing homes or in the community, whether paid primarily by Medicaid or private resources, reduce the need for inpatient hospital admissions and readmissions, which are paid for by Medicare. Conversely, poor-quality long-term care services result in sicker patients with more acute problems who appear in hospital emergency rooms expecting and then receiving Medicare-paid acute care services.

Medicare's stake in long-term care is not, of course, totally economic. More fundamentally, the structure and financing of long-term care services for the elderly are integrally related to the basic purposes and activities of the Medicare program. After all, essentially all aged long-term care clients are Medicare beneficiaries, and to the extent that Medicare's programmatic responsibilities to them extend beyond the narrowly financial, then the availability and quality of long-term care services are also issues for Medicare.

## No Private Sector Panaceas

In keeping with the ideological tenor of our times, as well as the quite widely shared and legitimate apprehension about the potential budgetary impacts of expanded public financing of long-term care, attention in recent years has increasingly focussed on possible mechanisms for increasing private resources available to finance long-term care services. For elderly Medicare beneficiaries, it is increasingly understood that long-term care, especially nursing home care, is the primary source of catastrophic expenditures. Further, even conservative projections of the growth of the elderly population over the next several decades suggest that, even without improved public benefits, existing use rates are likely to create an enormous drain on public funds. And the growing apparent relative affluence of at least some of the elderly, in a period of highly constrained public resources, has understandably led to consideration of ways of tapping private resources to pay for long-term care.

There has thus been considerable discussion of private long-term care insurance, of ideas such as individual medical accounts, modeled on IRA's, and of particular devices such as reverse annuity mortgages for the elderly. I would like to emphasize that, to the extent that any of or all of these approaches, or other private financing approaches not yet thought of, can successfully pass the test of a market with adequate consumer safeguards, I am all for them. But it would be a delusion to believe they can ever substantially relieve the call on public funds.

To begin with, the large majority of funds already in the long-term care system are private funds, and it will take some doing just to maintain that proportionate status quo as the population continues to age. As you know, something like half of all reported nursing home expenditures involve private resources. We do not have a good empirical handle on the extremely large, and growing, market for private in-home services, but I suspect that it at least rivals in magnitude the publicly-financed market. Perhaps most important, in terms of private contributions, are the cash and, more importantly, non-cash contributions of family care givers, especially the daughters and daughters-in-law of the frail elderly, to their care. In fact, for most American families with frail elderly relatives, the relevant financial base is not the individual's income and assets, but the family's, and from a public policy point of view I must express some skepticism about calling for increased contributions from that base in a period of reduced public support for expenses of higher education, job training, and child care. What data we have suggests that intergenerational transfers from the elderly to non-elderly relatives exceed those in the other direction, and if we are going to expend more of the elderly's resources for long-term care, something else in the equation will have to give.

More to the point, while the elderly in the aggregate may be relatively more affluent than they have been in the past, those most in need of long-term care are not the average elderly. Long-term care services are typically needed by the very old, and disproportionately by widows and other elderly persons living alone. The financial status of the 68 year-old retiree with a private pension and a 65 year-old spouse with a history of intermittent labor force participation bears little relevance to the 80 year-old widow whose sole source of income is Social Security, who constitutes a much more typical long-term care client.

Many elderly persons - as well, indeed, as many non-elderly persons - experience chronic disease and functional disability. Those with strong informal supports or considerable economic resources tend to find ways to get by. Those with neither the informal supports nor adequate financial resources are those who occupy our nursing homes, fill alternate care beds, or benefit most from community-based home care programs.

Given the amount of whole-life insurance that has been purchased by the American public in this century, it would be a mistake to underestimate the capacity of the private insurance industry to sell a considerable volume of long-term care insurance to those who could afford it. As simulations performed at the Brookings Institution, about which Dr. Weiner will have much more to say in a later panel will demonstrate, however, such insurance mechanisms will largely rearrange the form in which private resources are contributed to long-term care financing, rather than creating additional private resources to substitute for public resources. They may help the elderly protect their assets by reducing the disposable income - and thus the asset accumulation - people have before they become extremely old, but they will not replace Medicaid.

The real allocative or distributive issue in long-term care financing, it seems to me, is thus not so much the split between public and private resources, but rather the split between federal and state and local tax revenues. While we talk about the catastrophic financial effect of long-term care on many elderly households, the effect is equally catastrophic from the perspective of many state budget directors. As you well know, the primary impact of this phenomenon is that Medicaid, originally conceived as a health insurance program primarily for low income mothers, children, and workers temporarily out of the work force, now devotes the majority of its expenditures to the frail elderly, the great bulk of those expenditures being for nursing home, and increasingly, home care. Medicaid has, in effect, served as the catastrophic reinsurance program for Medicare, in a way that has not only had perverse fiscal effects within the federal system, but which, as you know all too well, has required the impoverishment of many of the elderly in order that they may qualify for financial eligibility under a welfare-oriented program.

## The Medical Component of Long-Term Care

While the bulk of long-term care expenditures are widely, and perhaps appropriately, conceived of as essentially supportive or custodial, the fact remains that most long-term care clients are seriously ill. Indeed, from a narrowly legal point of view, they cannot qualify for benefits under federal programs if the services they require are "merely" custodial. More to the point, one of the things that makes effective long-term care so complicated is that it comprises a complex and highly variable mix of medical, nursing, social, residential, nutritional, and other supportive services.

These services are all interrelated, just as the problems and needs of long-term care clients are all interrelated, and the most effective service programs are those that integrate them under unified or coordinated management in a way that reflects the unity of the human personalities of clients. Yet the need for unified services does not automatically imply the need for single-source funding. Given the reality of the situation, in which financing of services for long-term care clients now has considerable components of Medicare, federal Medicaid, state Medicaid, other state, and private resources, and given the increasing experience of skillful long-term care providers in aggregating such funds, it is entirely reasonable, if not optimally desirable, to expect such multiple funding to continue.

It is also entirely reasonable and desirable to expect Medicare to do its part. I think it is difficult to make an a priori argument that Medicare should pay for supportive nursing services, for example, in a general hospital, but not in the same client's home. To take another example, it is hard to justify Medicare paying for rehabilitative nursing in those settings where a so-called "rehabilitation hospital" or "rehabilitation hospital distinct part" is available, but not if the identical services are provided in an essentially identical facility described as a state-certified "skilled nursing facility." The services of professional nutritionists to assure medically and therapeutically appropriate diets are incorporated into the cost base for hospital payment under the Prospective Payment System, but for nursing home patients only in the tiny fraction of instances in which their stays meet current Medicare eligibility requirements, as variously and differentially interpreted by fiscal intermediaries from one part of the country to another.

Hence, I would like to propose to you the principle that, within the limits of the budgetarily and operationally feasible, Medicare provide coverage for medical services to Medicare beneficiaries regardless of the manner in which they are domiciled. To meet the definition of medical services, the benefits should be limited to those determined to be necessary by a physician, or incorporated in a formal plan of care within an appropriately-licensed facility or home health agency. One might, for budgetary and administrative purposes, limit the extent of such benefits in terms of duration, or by employing some arbitrary supposition about minimal amount of basic supportive services as being excluded from coverage. One could propose an infinite variety of details. The essential point is that it should be eminently possible to define such a set of medical services, which might appropriately be covered under the Medicare program, without at the same time committing Medicare to financial responsibility for all aspects of long-term care.

## What Medicare Should Cover

In terms of rationalizing Medicare payments for long-term care services, in other words, the problem is not the absence of medically-definable, conceptually-discrete services that are needed by and provided to long-term care clients. The problem is that there are too many of them. Even if one excluded all room and board, companionship, and personal care services from Medicare's ambit, the needed medical services, in the aggregate, cost more than one can reasonably expect Medicare to pay in the contemporary budgetary and political environment.

Some of those services are, however, provided to beneficiaries for whom Medicare coverage was envisioned in the original statute, and if Medicare is to begin assuming some part of its responsibility in long-term care, those services constitute a logical place to start. I refer specifically to post-hospital extended care services and post-hospital skilled home care services.

In the early years of Medicare, the capacity to distinguish between relatively short-stay, post-acute, clinically intensive, extended care facilities and services, and the patients who could benefit from them, on the one hand, and more conventional, longer-stay, primarily custodial nursing homes and nursing home patients, on the other hand, was largely lacking, and Medicare ended up paying for more than had been contemplated for services it wasn't supposed to cover. But we now know a lot more about how to distinguish between true extended care and longer-term nursing home services. In 1972, however, we gave up on efforts to distinguish among types of nursing home care or patients, merged the standards for short-stay and long-stay nursing homes, and permitted Medicare to essentially abandon the extended care benefit.

We not only have more knowledge now, but in one specific instance we have concrete experience as well. Since 1982, some small rural hospitals have been providing post-acute swing-bed services to Medicare beneficiaries in a way that appears to be cost-effective, qualitatively satisfactory, and welcomed by patients and their communities. Demonstration projects to extend that model to urban communities were twice called for by Congress, but never implemented by HCFA. Given the enormous excess capacity in America's hospitals, the increased demand for post-acute services generated by the Prospective Payment System, and the shortage in most communities of adequate resources to meet that demand, it is clear that re-creation of extended care benefits should be a first priority.

The Congress, I would respectfully suggest, should direct HCFA, in the very near future, to establish new standards for hospital-based, distinct-part extended care facilities; to devise appropriate reimbursement mechanisms consistent with - and not conflicting in incentives from - PPS; and, most importantly, to define a set of clinical conditions, functional levels, and appropriate therapeutic interventions which would identify those beneficiaries likely to benefit from, and therefore be eligible for, extended care services. That work could be performed in a relatively short time, drawing on existing and ongoing research. Once it has been completed, the Congress could clarify the existing statutory benefit, and give it life by requiring adoption of the necessary new standards and policies.

The problem with Medicare-covered home care is more complex. Twice in the last seven years Congress has sought to expand this benefit, while HCFA has succeeded at continually narrowing it through administrative action. Here, it would probably be necessary to redefine the benefit altogether, perhaps by restoring the prior hospitalization requirement, removing the homebound requirement, and mandating a system of professional - rather than fiscal intermediary - utilization controls, which could be modelled on those already successfully applied by many state Medicaid programs. Whether or not the care is "skilled" should not be the primary criterion for coverage; instead, coverage should be tied to patients' functional needs. It would also probably be helpful if we had a more sensible reimbursement system for home care, study of which you have already mandated, and more realistic and effective quality assurance standards.

## Financing Issues

In the somewhat longer term, any expansion - or even rationalization without significant expansion - of Medicare funding for long-term care should be tied to efforts to make more sensible the overall financing of long-term care. It is not necessary for Medicare to pay for all of long-term care in order to expect it to take a leadership role relative to other sources of funding.

Three separate, and not mutually exclusive, approaches should be encouraged. First, the financing model now being employed in the Social Health Maintenance Organization (SHMO) demonstration should be experimented with further. For the SHMO's, Medicare is paying 100% rather than 95%, of the AAPC; in addition, the AAPC is risk-adjusted. The SHMO's , in turn, charge a supplemental premium for a benefit package that includes some long-term care services, and will eventually be at full financial risk. Perhaps we should expand this model by having Medicare pay 100%, or even 105%, of the risk-adjusted AAPC to any TEFRA-qualified HMO or CMP that agrees to offer a set of specified long-term care services.

Second, we have to find ways to get Medicare and Medicaid to work together on behalf of long-term care clients. This is a problem, I need hardly tell you, not only of abstract policy design, but of intergovernmental relations, fiscal federalism, and even Congressional committee jurisdiction. One important step would be to establish procedures through which a single utilization review agent or case manager might be empowered to authorize both Medicare and Medicaid-covered services for particular clients. More ambitious, but still worthy of exploration, would be some Medicare subsidization of community-based services, now financed by Medicaid or private resources, that can be demonstrated to reduce utilization of services covered by Medicare. If effective community-based care can save Medicare money, common sense suggests Medicare would benefit by helping to pay for it. Conversely, to that extent that any expansion of Medicare reduces the demand on Medicaid to pay for certain services or cover certain people, the net impact on the federal treasury is reduced, and the states might be expected or required, to reallocate their savings to other recipients or potential recipients.

Finally, it is clear to me that we still have an awful lot to learn about how to provide and pay for high-quality long-term care services. We do know enough to suspect that there is probably no magic formula, no one best way that can be automatically applied for all clients in all communities. It is thus essential that we continue to experiment, to test new financing and delivery approaches, to encourage diversity and innovation.

Historically, the federal government has played an essential role in supporting, encouraging, and evaluating such research and demonstration efforts. That was no less true in long-term care than in other aspects of the human services. In the last five years or so, the federal government has largely abandoned this role, and as a result the level of experimentation and research has fallen substantially. Thus, as my last point, I would submit that our first priority should be to reinvigorate efforts to test new models of financing and care. I would recommend that you authorize HCFA to spend an additional $25 million a year in grant and contract funds, in conjunction with an aggressive program of both Medicare and Medicaid waivers, to this end. In the long run, that would probably be the most valuable initiative you could undertake now.

Again, I'm extremely grateful for the opportunity to appear before you this morning. I'd be happy to attempt to respond to any comments or questions you might have.

Thank you very much.

Chairman **Stark**. Bruce, you raise a whole lot of questions. I just have an outline of some of the key points in long-term care, and one of the things that is suggested is that the difference between a skilled nursing facility and an intermediate care facility gets very blurry. Some States, in fact, have dropped the distinction.

Is that a direction we should follow so that we do not get whole layers of different classifications of providers?

Mr. **Vladeck**. I think we have the wrong distinction at the moment. Again, historically, when the extended care facility was first defined, it was a hospital-based facility, admitting patients from the hospital for a relatively short and constrained stay. For a whole variety of reasons in the early years of Medicare, there were a lot of problems with that in its relationship to Medicaid-certified nursing homes.

So in the 1972 amendments we merged the Medicare and Medicaid standards. I have long been an advocate, when you are speaking of free-standing nursing homes with an average length of stay of a year-and-a-half or so, for merging the SNF and ICF standards and saying we should just have nursing homes.

But I think that is a distinct service from what I would call extended care, which again was the pre-1972 definition of the benefit, which is very much more oriented at relatively short stay, postacute, discharge home kinds of services.

I think the need for that has grown continuously as the Medicare population has grown. We have learned a lot more about those services. We have the swing beds and other examples now. So over time, I would say, for the free-standing long-stay nursing home, merge the SNF and ICF standards, but then go back and define an extended care facility—whatever the terminology—that is closely connected to hospitalizations. I think there is a very great need for that. I think having the dual facility standards on the free-standing side makes it harder to figure out your way to get to extended care.

Chairman **Stark** Is it possible to make a clear definition between what Medicare pays in long-term care and what it does not? Or does that get so blended?

Mr. **Vladeck**. I think at the moment, if you look at the statute, there is a reasonable degree of clarity with some fuzziness. If you look at what actually is going on out there, with the amount of discretion that the intermediaries have traditionally exercised, with enormous variation in intermediary practices from one federal region to another, let alone from one intermediary clerk to another, that those benefits have become entirely fuzzed up.

Under any circumstances, I think it would be necessary to clean up that act. As you are doing it, I think there is a case to be made for strengthening some of those benefits rather than just continuing to narrow them.

Chairman **Stark**. You have talked about it being easy to define a set of Medicare benefits that we ought to have. I would love to see it in more detail. I mean, it is one thing for those of us who are not in the profession of providing care day-to-day to think through a whole set of details. It is much easier for us to criticize yours.

Mr. **Vladeck**. I understand.

Chairman **Stark**. And I would, for one, be most anxious to see what kinds of rules, definitions, and restrictions on the gatekeeper or what kind of a gatekeeping system, if there is one. I am not aware, and I am sure there are, of a variety of programs around the country, all of which should have bits and pieces of definitions and guidelines. And if you have one, I would like to see it.

Mr. **Vladeck**. I would be happy to submit something to you afterwards. If I could make just one quick point about that, many state Medicaid programs have needed to engage in a very similar exercise and have become more and more sophisticated over time in defining eligibility or applicability of their benefits. It will be very easy for me, frankly, to borrow some of their material to illustrate the sorts of things I think we could do under the Medicare program.

[The following was subsequently received:]

April 21, 1987

Joseph K. Dowley
Chief Counsel
Committee on Ways and Means
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Dowley:

As requested, I enclose the edited version of my testimony before the Subcommittee on Health on March 31.

During the hearing, Chairman Stark requested that I provide some illustrative material on criteria employed by state Medicaid programs to determine the range of services that are being provided to long-term care clients with different characteristics. In response to the Chairman's request, I also attach the following:

- The New York State Patient Review Instrument (PRI), which is employed both to determine eligibility for nursing home care, and to classify patients into 1 of 16 Resource Utilization Groups (RUG), a case classification system for nursing homes somewhat analogous to DRGs. Hypothetically, one might, for example, establish Medicare eligibility for a small number of RUGs. The New York State Health Department considers the reliability and validity of this data to be very high.
- The New York State "SCREEN," which is employed to determine whether or not a patient might be serviced in home care before any referral may be made to a nursing home.
- A packet of material from the Massachusetts Department of Public Welfare on mechanisms for assessing appropriate levels of care for Medicare clients requiring either nursing home or long-term community care.

I would be happy to provide you with any more information that might be helpful, but would respectfully suggest that on these issues the relevant state agencies have more information and expertise.

Sincerely,

Bruce C Vladeck

Bruce C. Vladeck

BCV:hkh
Encs.

New York State Department of Health

RUG II Group (print name):

RHCF Level of Care
☐ HRF ☐ SNF

## HOSPITAL AND COMMUNITY
## PATIENT REVIEW INSTRUMENT (H/C-PRI)

**Use with separate Hospital and Community PRI Instructions**

## I. ADMINISTRATIVE DATA

1 OPERATING CERTIFICATE NUMBER (1-8) ☐☐☐☐☐☐☐☐

2 SOCIAL SECURITY NUMBER (9-17) ☐☐☐ ☐☐ ☐☐☐☐

3 OFFICIAL NAME OF HOSPITAL OR OTHER AGENCY/FACILITY COMPLETING THIS REVIEW

4 PATIENT NAME (AND COMMUNITY ADDRESS IF REVIEWED IN COMMUNITY)

5 DATE OF PRI COMPLETION (18-25) ☐☐ MO ☐☐ DAY 1 9 ☐☐ YEAR

6 MEDICAL RECORD NUMBER/CASE NUMBER (26-34) ☐☐☐☐☐☐☐☐☐

7 HOSPITAL ROOM NUMBER (35-39) ☐☐☐☐☐

8 NAME OF HOSPITAL UNIT/DIVISION/BUILDING

9 DATE OF BIRTH (40-47) ☐☐ MO ☐☐ DAY ☐☐☐☐ YEAR

10 SEX
1 = Male
2 = Female (48) ☐

11A DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT (49-56) ☐☐ MO ☐☐ DAY 1 9 ☐☐ YEAR

11B DATE OF ALTERNATE LEVEL OF CARE STATUS IN HOSPITAL (IF APPLICABLE) (57-64) ☐☐ MO ☐☐ DAY 1 9 ☐☐ YEAR

12 MEDICAID NUMBER (65-75) ☐☐☐☐☐☐☐☐☐☐☐

13 MEDICARE NUMBER (76-85) ☐☐☐☐☐☐☐☐☐☐

14 PRIMARY PAYOR
1 = Medicaid
2 = Medicare
3 = Other (86) ☐

15 REASON FOR PRI COMPLETION
1. RHCF Application from Hospital
2. RHCF Application from Community
3. Other (Specify: ________________)
(87) ☐

## II. MEDICAL EVENTS

16 **DECUBITUS LEVEL:** ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS. (88) ☐

17 **MEDICAL CONDITIONS:** DURING THE PAST WEEK. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS.
1 = Yes 2 = No (89-96)

A. Comatose .............................. ☐
B. Dehydration .............................. ☐
C. Internal Bleeding .............................. ☐
D. Stasis Ulcer .............................. ☐
E. Terminally Ill .............................. ☐
F. Contractures .............................. ☐
G. Diabetes Mellitus .............................. ☐
H. Urinary Tract Infection .............................. ☐

18 **MEDICAL TREATMENTS:** READ THE INSTRUCTIONS FOR QUALIFIERS. 1 = Yes 2 = No (97-109)

A. Tracheostomy Care/Suctioning (Daily — Exclude self care) .............. ☐
B. Suctioning — General (Daily) .......... ☐
C. Oxygen (Daily) .......................... ☐
D. Respiratory Care (Daily) .............. ☐
E. Nasal Gastric Feeding .................. ☐
F. Parenteral Feeding ...................... ☐
G. Wound Care .............................. ☐
H. Chemotherapy .............................. ☐
I. Transfusion .............................. ☐
J. Dialysis .............................. ☐
K. Bowel and Bladder Rehabilitation ....... (SEE INSTRUCTIONS) ☐
L. Catheter (Indwelling or External) ........ ☐
M. Physical Restraints (Daytime Only) ..... ☐

## III. ACTIVITIES OF DAILY LIVING (ADLs)

**Measure the capability of the patient to perform each ADL 60% or more of the time it is performed during the past week (7 days). Read the Instructions for the Changed Condition Rule and the definitions of the ADL terms.**

**19** **EATING:** PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE, PLATE, CUP, TUBE)

**19** ☐ (110)

1 = Feeds self without supervision or physical assistance. May use adaptive equipment.

2 = Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.

**3 = Requires continual help (encouragement/teaching/physical assistance)with eating or meal will not be completed.**

**4 = Totally fed by hand, patient does not manually participate.**

**5 = Tube or parenteral feeding for primary intake of food. *(Not* just for supplemental nourishments.)**

**20** **MOBILITY:** HOW THE PATIENT MOVES ABOUT.

**20** ☐ (111)

1 = Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.

2 = Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).

**3 = Walks with *constant* one-to-one supervision and/or constant physical assistance.**

**4 = Wheels with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.**

**5 = Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.**

**21** **TRANSFER:** PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING, (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET).

**21** ☐ (112)

1 = Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.

2 = Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.

**3 = Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.**

**4 = Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.**

**5 = Cannot and is not gotten out of bed.**

**22** **TOILETING:** PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN). TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES.

**22** ☐ (113)

1 = Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.

2 = Requires *intermittent* supervision for safety or encouragement, or *minor* physical assistance (for example, clothes adjustment or washing hands).

**3 = Continent of bowel *and* bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, *including* appliances (i.e., colostomy, ileostomy, urinary catheter).**

**4 = Incontinent of bowel *and/or* bladder and is not taken to a bathroom.**

**5 = Incontinent of bowel *and/or* bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.**

## IV. BEHAVIORS

**23** **VERBAL DISRUPTION:** BY YELLING, BAITING, THREATENING, ETC.

**23** ☐ (114)

1 = No known history.

2 = Known history or occurences, but not during the past week (7 days).

3 = Short-lived or predictable disruption regardless of frequency (for example, during specific care routines, such as bathing.)

**4 = Unpredictable, recurring verbal disruption at least once during the past week (7 days) for no foretold reason.**

**5 = Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions).**

**24** **PHYSICAL AGGRESSION:** ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH **INTENT FOR INJURY.** (FOR EXAMPLE HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR)

**24** ☐ (115)

1 = No known history.

2 = Known history or occurences, but not during the past week (7 days).

3 = Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.

**4 = Unpredictable, recurring aggression at least once during the past week (7 days) for no apperent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).**

**5 = Patient is at level as #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions).**

NAME (PLEASE PRINT) ______________________________

**25 DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR:** CHILDISH, REPETITIVE OR ANTISOCIAL PHYSICAL BEHAVIOR WHICH CREATES *DISRUPTION WITH OTHERS*. (FOR EXAMPLE, CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESELF TO OTHERS). EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS.

1 = No known history.

2 = Displays this behavior, but is not disruptive to others (for example, rocking in place).

3 = Known history or occurences, but not during the past week. (7 days).

4 = Occurences of this disruptive behavior at least once during the past week (7 days).

5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).

**25** (116) ☐

**26 HALLUCINATIONS:** EXPERIENCED AT LEAST ONCE DURING THE PAST WEEK. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY.

1 = Yes

2 = No

3 = Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

**26** (117) ☐

## V. SPECIALIZED SERVICES

**27 PHYSICAL AND OCCUPATIONAL THERAPIES:** READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS).

A. Physical Therapy (P.T.) ..........

B. Occupational Therapy (O.T.) ..........

| | | |
|---|---|---|
| P.T. Level (118) | ☐ | |
| P.T. Days (119) | ☐ | |
| P.T. Time (120-123) | ☐☐ HOURS | ☐☐ MIN / WEEK |
| O.T. Level (124) | ☐ | |
| O.T. Days (125) | ☐ | |
| O.T. Time (126-129) | ☐☐ HOURS | ☐☐ MIN / WEEK |

**LEVEL**

1 = Does not receive.

2 = Maintenance Program - Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration.

3 = Restorative Therapy - Requires and is currently receiving physical and/or occupational therapy for the past week.

4 = Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, therapy provided for only two days).

**DAYS AND TIME PER WEEK:** ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS) THAT EACH THERAPY WAS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

**28 NUMBER OF PHYSICIAN VISITS: DO NOT ANSWER THIS QUESTION FOR HOSPITALIZED PATIENTS, (ENTER ZERO), UNLESS ON ALTERNATE LEVEL OF CARE STATUS.** ENTER ONLY THE NUMBER OF VISITS DURING THE PAST WEEK THAT ADHERE TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. THE PATIENT MUST BE MEDICALLY UNSTABLE TO ENTER ANY PHYSICIAN VISITS, OTHERWISE ENTER A ZERO.

**28** (130-131) ☐☐

## VI. DIAGNOSIS

**29 PRIMARY PROBLEM:** THE MEDICAL CONDITION REQUIRING THE LARGEST AMOUNT OF NURSING TIME IN THE HOSPITAL OR CARE TIME IF IN THE COMMUNITY. (FOR HOSPITALIZED PATIENTS THIS MAY OR MAY NOT BE THE ADMISSION DIAGNOSIS).

ICD—9 Code of medical problem .......... **29** (132-136) ☐☐☐.☐☐

If code cannot be located, print medical name here.

## VII. PLAN OF CARE SUMMARY

**This section is to communicate to providers any additional clinical information which may be needed for their preadmission review of the patient. It does not have to be completed if the information below is already provided by your own form, which is attached to this H/C - PRI.**

**30 DIAGNOSES AND PROGNOSES:** FOR EACH DIAGNOSIS DESCRIBE THE PROGNOSIS AND CARE PLAN IMPLICATIONS

| Primary | Prognosis |
|---|---|
| 1 | |

Secondary (Include Sensory Impairments)

1.
2
3
4

**31 REHABILITATION POTENTIAL** [INFORMATION FROM THERAPIST(S)]

A POTENTIAL DEGREE OF IMPROVEMENT WITH ADLs WITHIN SIX MONTHS (DESCRIBE IN TERMS OF ADL LEVELS ON THE HC—PRI).

B CURRENT THERAPY CARE PLAN: DESCRIBE THE TREATMENTS (INCLUDING WHY) AND ANY SPECIAL EQUIPMENT REQUIRED.

**32 MEDICATIONS**

| NAME | DOSE | FREQUENCY | ROUTE | DIAGNOSIS REQUIRING EACH MEDICATION |
|---|---|---|---|---|

**33 TREATMENTS:** INCLUDE ALL DRESSINGS, IRRIGATIONS, WOUND CARE, OXYGEN.

| A. TREATMENTS | DESCRIBE WHY NEEDED | FREQUENCY |
|---|---|---|

B. NARRATIVE: DESCRIBE SPECIAL DIET, ALLERGIES, ABNORMAL LAB VALUES, PACEMAKER.

---

**34 QUALIFIED ASSESSOR:** I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS H/C-PRI: ☐ YES ☐ NO

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

SIGNATURE OF QUALIFIED ASSESSOR

IDENTIFICATION NO. ☐☐☐☐☐

NEW YORK STATE DEPARTMENT OF HEALTH

# SCREEN

REVIEW COMPLETED PATIENT REVIEW INSTRUMENT (PRI) BEFORE BEGINNING SCREEN. Use with separate PRI and SCREEN instructions and training manual

## I. IDENTIFICATION

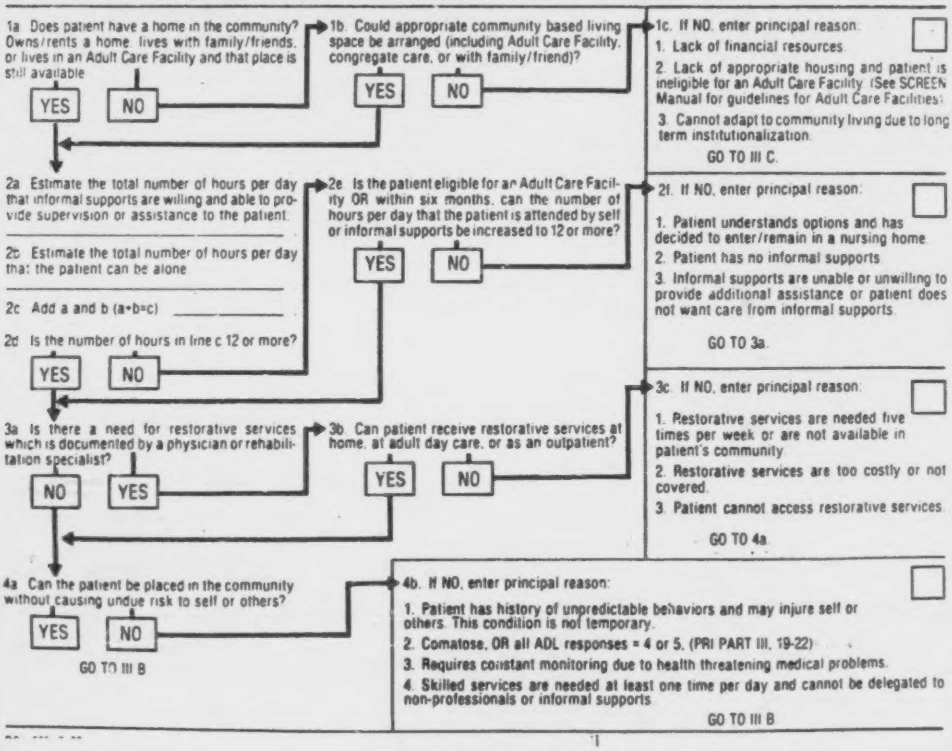
| | |
|---|---|
| 1. Facility Operating Certificate Number: \| \| \| \| \| \| \| \| | 4. Patient Name: |
| 2. Patient Social Security Number: \| \| \|–\| \|–\| \| \| | 5. Date of HC-PRI or PRI completion: MONTH \| \|– DAY \| \|– YEAR 1 9 \| |
| 3. Name of person completing SCREEN: | 6. Date of SCREEN completion: MONTH \| \|– DAY \| \|– YEAR 1 9 \| |

## II A. DIRECT REFERRAL FACTORS FOR HOME ASSESSMENT:

| | YES | NO |
|---|---|---|
| 1. Patient understands information given and strongly opposes placement/continued stay in a nursing home | ☐ | ☐ |
| 2. Patient is aware of the cost of necessary community services and desires to use private resources (e.g. insurance, income, savings) to purchase care at home or in an Adult Care Facility | ☐ | ☐ |
| 3. Patient has a good informal support system - willing and capable (physically and mentally) of caring for most of the specific needs of the patient | ☐ | ☐ |
| 4. All ADL responses = 1 OR 2 (see PRI PART III, 19-22) | ☐ | ☐ |
| 5. Patient was independent in ADL prior to most recent acute episode and shows good rate of return of physical and mental functioning | ☐ | ☐ |

**II B. REFERRAL GUIDELINES:** If any direct referral factor (1-5) is marked YES, refer to Home Assessment or Assessment for Adult Care Facility. Proceed to Part III B. 2. If no direct referral factors (1-5) are marked YES, proceed to III A. HOME AND CAREGIVING ARRANGEMENTS

**III A. HOME AND CAREGIVING ARRANGEMENTS:** Circle YES and NO boxes to document each response. For questions on the far right, enter the number of the answer that best applies.



1a. Does patient have a home in the community? Owns/rents a home, lives with family/friends, or lives in an Adult Care Facility and that place is still available

YES NO

1b. Could appropriate community based living space be arranged (including Adult Care Facility, congregate care, or with family/friend)?

YES NO

1c. If NO, enter principal reason: ☐

1. Lack of financial resources
2. Lack of appropriate housing and patient is ineligible for an Adult Care Facility. (See SCREEN Manual for guidelines for Adult Care Facilities)
3. Cannot adapt to community living due to long term institutionalization.

GO TO III C.

2a. Estimate the total number of hours per day that informal supports are willing and able to provide supervision or assistance to the patient: ______

2b. Estimate the total number of hours per day that the patient can be alone ______

2c. Add a and b (a+b=c) ______

2d. Is the number of hours in line c 12 or more?

YES NO

2e. Is the patient eligible for an Adult Care Facility OR within six months, can the number of hours per day that the patient is attended by self or informal supports be increased to 12 or more?

YES NO

2f. If NO, enter principal reason: ☐

1. Patient understands options and has decided to enter/remain in a nursing home
2. Patient has no informal supports
3. Informal supports are unable or unwilling to provide additional assistance or patient does not want care from informal supports.

GO TO 3a.

3a. Is there a need for restorative services which is documented by a physician or rehabilitation specialist?

NO YES

3b. Can patient receive restorative services at home, at adult day care, or as an outpatient?

YES NO

3c. If NO, enter principal reason: ☐

1. Restorative services are needed five times per week or are not available in patient's community
2. Restorative services are too costly or not covered.
3. Patient cannot access restorative services.

GO TO 4a

4a. Can the patient be placed in the community without causing undue risk to self or others?

YES NO

GO TO III B

4b. If NO, enter principal reason: ☐

1. Patient has history of unpredictable behaviors and may injure self or others. This condition is not temporary.
2. Comatose, OR all ADL responses = 4 or 5. (PRI PART III, 19-22)
3. Requires constant monitoring due to health threatening medical problems.
4. Skilled services are needed at least one time per day and cannot be delegated to non-professionals or informal supports.

GO TO III B

**III B. PREVIOUS HOME ASSESSMENT:**

1 A home care agency has completed a full assessment of the patient's home situation and determined that the patient cannot be cared for at home or in an Adult Care Facility ........................................ YES ☐

2 Date of home assessment ________________

3 Home assessment completed by (agency):

agency phone:

**III C. REFERRAL GUIDELINES:**

1. If there are no entries in the boxes on the right in III A and III B, refer to Home Assessment or Assessment for Adult Care Facility. Proceed to Part IV.
2. If there is an entry in box III A.3c., refer to RHCF for restorative services. Proceed to Part IV.
3. If there are entries in other boxes on the right in III A and III B, could these problems be addressed in a home care plan or in an Adult Care Facility?

☐ YES Refer to Home Assessment or Assessment for Adult Care Facility. Proceed to Part IV.
☐ NO Refer to RHCF. Proceed to Part IV.

**IV. A. REFERRAL DECISION:**

Enter the referral decision indicated by the SCREEN.

1 ☐ Home Assessment or Assessment for Adult Care Facility
2 ☐ RHCF for restorative services
3 ☐ RHCF for other services

**B. PATIENT'S DISPOSITION:**

1. ☐ Home
2. ☐ Home with home care services
3. ☐ Adult Care Facility
4. ☐ Adult Care Facility with home care services
5. ☐ RHCF for restorative services
6. ☐ RHCF for other services
7. ☐ Patient died
8. ☐ Other (specify) ________________

**V. QUALIFIED SCREENER:** I have personally observed/interviewed this patient and completed this SCREEN: ☐ YES ☐ NO.
I certify that I am a trained and qualified screener and the information contained herein is a true abstract of the patient's condition and circumstances.

______________________________
SIGNATURE OF QUALIFIED SCREENER

Screener Identification Number (assigned by NYS DOH): ☐☐☐☐☐

**VI. UPDATE:** The information contained herein has not changed and is a true abstract of the patient's condition and circumstances.

☐☐☐☐☐
SIGNATURE OF TRAINED AND QUALIFIED SCREENER — SCREENER IDENTIFICATION NUMBER
Review date: HC-PRI or PRI: / / SCREEN: / /

☐☐☐☐☐
SIGNATURE OF TRAINED AND QUALIFIED SCREENER — SCREENER IDENTIFICATION NUMBER
Review date: HC-PRI or PRI: / / SCREEN: / /

☐☐☐☐☐
SIGNATURE OF TRAINED AND QUALIFIED SCREENER — SCREENER IDENTIFICATION NUMBER
Review date: HC-PRI or PRI: / / SCREEN: / /

☐☐☐☐☐
SIGNATURE OF TRAINED AND QUALIFIED SCREENER — SCREENER IDENTIFICATION NUMBER
Review date: HC-PRI or PRI: / / SCREEN: / /

Department of Public Welfare
600 Washington Street, Boston 02111

MEDICAL ASSISTANCE PROGRAM
LONG-TERM-CARE FACILITY
BULLETIN 28
March 1982

TO: Long-Term-Care Facilities Participating in the Medical Assistance Program

RE: New Regulations Concerning Level-of-Care Criteria

Attached to this bulletin are new regulations governing the provision of long-term-care services under the Medical Assistance Program. The new regulations set forth the Department's medical and psychosocial criteria for determining a recipient's need for skilled nursing or intermediate care facility services and are based on the current guidelines, which they will replace. The major differences between the current guidelines and the new regulations are listed below.

1. A "Special Circumstances" section (Section 456.265) has been added to clarify the factors that should be considered for recipients with sensory impairment, mental state impairment, or a pacemaker.

2. The psychosocial criteria have been modified. Certain additional documentation requirements are specified and the factors of length of stay, adjustment problems, reality orientation, key relationships, incontinence, and previous transfers have been eliminated.

The new level-of-care criteria take effect on April 1, 1982.

If you have questions about the new regulations, you should contact the Director of Utilization Control in the Medical Division at (617) 727-8084.

106 CMR 456.000: MEDICAL ASSISTANCE PROGRAM: LONG-TERM-CARE SERVICES

106 CMR 456.000 is amended by adding the following sections:

Section

LEVEL-OF-CARE CRITERIA
456.251 Introduction
456.252 Definition of Skilled Services
456.253 Skilled Nursing Facility Services: Level-of-Care Criteria
456.254 Skilled Nursing Services
456.255 Skilled Rehabilitation Services
456.256 Other Skilled Services
(106 CMR 456.257 through 456.259 Reserved)
456.260 Intermediate Care Facility Services: Level-of-Care Criteria
456.261 Restorative Services
456.262 Assistance in Activities of Daily Living
456.263 Other Intermediate Care Facility Services
(106 CMR 456.264 Reserved)
456.265 Special Circumstances
(106 CMR 456.266 through 456.269 Reserved)
456.270 Psychosocial Criteria

## LEVEL-OF-CARE CRITERIA

### 456.251: Introduction

(A) The regulations in Sections 456.252 through 456.270 establish minimum medical criteria for determining a recipient's need for skilled nursing facility or intermediate care facility services provided under the Medical Assistance Program. These regulations also establish psychosocial criteria that, when present, could indicate the need for a recipient to remain in a skilled nursing facility or intermediate care facility.

(B) The Department will approve payment for skilled nursing or intermediate care facility services for only those recipients who meet the level-of-care or psychosocial criteria in Sections 456.252 through 456.270 and who cannot receive the needed care and services in a noninstitutional setting.

(C) Documentation in the recipient's medical record required by these regulations is in addition to any other recordkeeping requirements of the Department and the Massachusetts Department of Public Health.

### 456.252: Definition of Skilled Services

A skilled service is a nursing, rehabilitative, therapeutic, or other medical or medically related service that must be provided either directly by or under the general supervision of a registered nurse or licensed therapist. The Department pays for skilled services only when these services are necessary to prevent physical deterioration or to maintain existing functional capacities. Skilled services must be provided in an institutional setting because of the intensity, length of time, or frequency that they are needed.

### 456.253: Skilled Nursing Facility Services: Level-of-Care Criteria

To be eligible for skilled nursing facility services, a recipient must meet the criteria in either Subsection (A) or (B) below and must require these services in an institutional setting.

(A) The recipient has been deemed ineligible for Medicare benefits but requires skilled nursing or rehabilitation services as specified in 42 CFR 405.127 and must, because of his physical condition, receive those services in a skilled nursing facility.

(B) The recipient requires one of the following:
(1) skilled nursing services seven days a week;
(2) skilled rehabilitation services five days a week; or
(3) a combination of different skilled services on different days, but at least one skilled service every day.

## 456.254: Skilled Nursing Services

Skilled nursing services include, but are not limited to, the following:

(A) nursing observation and care for a recipient's unstable or complex medical condition (for example, brittle diabetes or blood dyscrasia);

(B) administration of oral or injectable medications that require the judgment and direction of a registered nurse to monitor the dosage and frequency and to observe the recipient for any adverse reactions to the medication. Drugs with life-threatening side effects, given as treatment for an acute condition, may require skilled nursing care. Administration of the same drug, given in a reduced dosage as a maintenance regimen, does not, in itself, indicate the need for skilled nursing care, nor does a 24-hour medication regimen;

(C) nasopharyngeal aspiration and tracheotomy care; however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled nursing services;

(D) levin tube and gastrostomy feedings;

(E) administration of parenteral solutions on a regular and continuous basis;

(F) care of a colostomy either during an early postoperative period when related medical complications are present or when provided in combination with colostomy training. General continuous maintenance care of a colostomy can usually be performed by the patient himself or by a person without skilled training and, therefore, does not, in itself, indicate the need for skilled nursing services;

(G) care of a suprapubic catheter or care of a urethral catheter when the insertion and maintenance of the urethral catheter is part of an active treatment for a disease of the urinary tract and irrigation is required for medical reasons (for example, when a recipient has cancer of the bladder or a resistant bladder infection).
(1) When care of a urethral catheter is the basis for

recommending or approving the need for skilled nursing care, the urethral catheter must be prescribed by a physician and the need for the catheter must be documented in the recipient's medical record.
(2) The presence of a urethral catheter, particularly one placed for convenience, for the control of incontinence, or for routine irrigation, does not, in itself, indicate the need for skilled nursing care.
(3) For the purposes of this subsection, a urinary tract infection caused by the use of a catheter does not constitute a disease condition;

(H) administration of oxygen or other medical gases when they are needed on a regular and continuing basis because of the recipient's medical condition (for example, when the recipient has chronic obstructive pulmonary disease or pulmonary edema); and

(I) treatment of deep decubitus ulcers (deep area with or without necrotic tissue) or deep skin lesions when the physician has prescribed irrigation or the application of medication or sterile dressings. Infected skin lesions may require skilled nursing care to prevent the spread of the infection to other patients. When care of infected skin lesions is the basis for recommending or approving the need for skilled nursing care, the need must be documented in the recipient's medical record.

## 456.255: Skilled Rehabilitation Services

Skilled rehabilitation services must be provided as part of an integrated program of medical care, restorative services, and special therapy that includes physical therapy, occupational therapy, speech therapy, and audiology services. These services must be prescribed by a physician. Skilled rehabilitation services include, but are not limited to, the following:

(A) ongoing assessment of a recipient's rehabilitation needs that is performed concurrently with the management of a patient care plan and that is based on tests or measurements of range of motion, strength, balance, coordination, endurance, functional ability, dependence in activities of daily living, perception, speech, language, and hearing;

(B) exercises or activities that are designed to restore, maintain, or improve mental or physical functional ability and that must be performed by or under the supervision of a qualified physical or occupational therapist to ensure the safety of the recipient and the effectiveness of the treatment;

(C) range-of-motion exercises that are part of a planned program of care that includes skilled nursing care and that are a prescribed treatment for a specific condition that has resulted in a loss or restriction of mobility. The degree of motion lost and the motion restoration goals of the treatment program must be specified in the recipient's medical record;

(D) therapy that is provided as part of a planned program of care that includes skilled nursing and a therapy program designed, established, and directed by a qualified therapist. The findings of an initial evaluation and of periodic reassessments of the recipient must be included in the recipient's medical record;

(E) administration of a hot pack, a hydrocollator, infrared treatment, a paraffin bath, or whirlpool treatments when the recipient's primary diagnosed condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or fractures; and

(F) speech therapy or audiology services within the facility when such services are needed for the improvement of the recipient's speech or hearing.

## 456.256: Other Skilled Services

(A) Skilled Management of an Aggregate of Services.

(1) A recipient may need skilled nursing facility services if his medical condition is such that his recovery or safety can be ensured only if the total care given to him is planned, managed, and evaluated by a registered nurse.

(2) In cases where a recipient's full recovery or improvement is not possible, skilled care may be needed to prevent further deterioration of the recipient's condition.

(3) When the recipient is recommended or approved for skilled nursing facility services under the criteria in this subsection, the recipient's medical record must clearly indicate the reasons that skilled management of those services is required.

(B) Skilled Planning, Management, and Evaluation of the Recipient's Care Plan. A recipient may require skilled nursing facility services if his care plan must be planned, managed, and evaluated by licensed personnel to promote his recovery and to ensure his medical safety because he requires assistance in all activities of daily living, including the following:

(1) transferring: the recipient must be a bed patient who cannot be transferred, must be lifted to be transferred, or must require the physical assistance of another person to be transferred;

(2) walking or wheeling: the recipient must be unable to walk or must require the assistance of another person, with or without mechanical assistance;

(3) bathing: the recipient must be unable to bathe himself;

(4) dressing: the recipient must be unable to dress himself or cannot be dressed because he is bedridden; and

(5) bladder or bowel function: the recipient must be incontinent of bladder or bowel function day and night, or he must require scheduling assistance with bladder or bowel continence, or both. For the purposes of this subsection, incontinence shall also mean that the recipient cannot self-toilet at any time.

(106 CMR 456.257 through 456.259 Reserved)

## 456.260: Intermediate Care Facility Services: Level-of-Care Criteria

To be eligible for intermediate care facility services, a recipient must meet the following criteria and must require these services in an institutional setting:

(A) he has a medical or mental dysfunction that requires nursing care and services to meet medical or psychosocial needs. The dysfunction may involve one or more physiological systems and may not necessarily be stabilized; and

(B) he requires one of the following:
(1) skilled services on a infrequent basis (that is, less than seven days per week);
(2) restorative services;
(3) assistance in any activities of daily living; or
(4) other intermediate care services.

## 456.261: Restorative Services

Restorative services must be required to achieve maximum use of physical or mental capabilities, to prevent physical or mental deterioration, or to maintain optimal functioning. The recipient must require these services in an institutional setting because of the intensity, duration, or frequency of need for the services, the lack of appropriate community services to meet those needs, or both. Restorative services include, but are not limited to, the following:

(A) management of orthotic or prosthetic devices such as casts, braces, or splints. The presence of an orthotic or prosthetic device does not usually require skilled nursing care. If there are other related medical conditions or specific medical complications that necessitate skilled care, these conditions or complications must be documented in the recipient's medical record;

(B) proper positioning in bed or in a wheelchair, changing of position, or other such care to prevent deformity and decubitus ulcers;

(C) prevention of skin irritation and decubitus ulcers including the provision of prophylactic and palliative skin care, such as bathing and the application of creams and lotions. The prevention of skin irritation and decubitus ulcers in some recipients may require skilled nursing care. If it is determined that skilled nursing care is required, documentation of that need must appear in the recipient's medical record;

(D) treatment of skin irritations, small superficial lesions, or superficial decubitus ulcers (reddened area with or without a superficial break in skin);

(E) routine changing of dressings that requires nursing care or direction; and

(F) range-of-motion exercises that are part of a routine maintenance program to prevent contractures and to maintain mobility.

## 456.262: Assistance in Activities of Daily Living

A recipient may require care in an intermediate care facility if he needs assistance in any activities of daily living. A recipient whose only need is for 24-hour supervision is not appropriate for care in an intermediate care facility. Assistance in activities of daily living includes, but is not limited to, the following services:

(A) provision of training in any activity of daily living in order to improve or maintain the recipient's functional level;

(B) assistance in transferring (for example, from a bed to a wheelchair, from a wheelchair to a commode, or from a bed to a chair);

(C) assistance in the use of a cane, a walker, or other such devices. A restorative or maintenance program that is prescribed or developed by a physician or a physical therapist can be conducted in an intermediate care facility;

(D) assistance in bathing, dressing, and grooming;

(E) provision of special diets with continuous supervision to maintain good nutrition and to prevent nutritional deficiencies. The inability to feed oneself or the need for assistance with eating does not, in itself, indicate the need for intermediate care facility services; and

(F) care or training, or both, in bladder and bowel function, such as the routine care of an indwelling catheter, implementation of a time-control program for bladder and bowel incontinence, or maintenance care of an uncomplicated and regulated colostomy or ileostomy.

## 456.263: Other Intermediate Care Facility Services

Other services that, if needed, may necessitate care in an intermediate care facility include, and ordinarily are limited to, the following:

(A) monitoring of vital signs and recording of the observations in the recipient's medical record;

(B) application of topical, oral, or certain injectable medications. Injectable medications should be administered either by the recipient under supervision or by a licensed nurse;

(C) application or supervision of the use of palliative treatments using devices such as a whirlpool or a hydrocollator;

(D) routine administration of oxygen when a regimen of use has been prescribed by a physician and when proper oxygen storage is available in accordance with the conditions outlined by the Massachusetts Department of Public Health in its "Rules and Regulations for the Licensing of Long-Term Care Facilities" (105 CMR 150.000);

(E) intermittent use of positive pressure breathing equipment and nebulizers when a stable regimen has been established for conditions such as chronic asthma or emphysema;

(F) use of protective restraints, bed rails, binders, poseys, or other supports when ordered by the recipient's physician and when provided in accordance with written patient-care policies and procedures and a written care plan; and

(G) assistance to a recipient who has a self-care tracheotomy.

(106 CMR 456.264 Reserved)

## 456.265: Special Circumstances

(A) Sensory Impairment. Sensory loss or impairment is not, in itself, an indication that the recipient requires care in an institutional setting, nor does it indicate the need for a specific level of care. In determining the appropriate care site and the appropriate level of care for a recipient, sensory impairment must be considered with all other factors that indicate the amount, duration, and scope of services necessary.

(B) Mental State Impairment. A recipient who exhibits mental state impairment such as confusion, disorientation in time, place, or person, memory loss, or defective judgment may require care in an institutional setting. However, mental state impairment is not, in itself, an indication that the recipient requires care in an institutional setting, nor does it indicate the need for a specific level of care. In determining the appropriate care for a recipient, mental state impairment must be considered with all other factors that indicate the amount, duration, and scope of services necessary. If a transfer to a higher level of care is recommended for a recipient in an intermediate care facility because of mental state impairment or because the recipient exhibits behavior that is detrimental to himself or to others, the recipient's medical record must contain a written report of a medical examination by a physician and a psychiatric evaluation by a psychologist that documents that the recipient cannot be managed in an intermediate care facility or a noninstitutional setting.

(C) Pacemaker. The presence of a pacemaker may indicate the need for intermediate care facility or skilled nursing facility services; however, it is not, in itself, a sufficient reason for recommending these services. If intermediate care facility or skilled nursing facility services are recommended for a recipient with a pacemaker, the need for such care must be documented in the recipient's medical record.

(106 CMR 456.266 through 456.269 Reserved)

## 456.270: Psychosocial Criteria

When a recipient is determined according to the Department's level-of-care criteria to be inappropriately placed in a skilled nursing or intermediate care facility, certain factors must exist to justify continued stay at an otherwise inappropriate level of care. These factors are listed below. They are not intended to supersede the level-of-care criteria. They shall not be used in determining the placement of a recipient on admission. They shall be used in justifying a continued stay at an inappropriate level only when it is documented in the recipient's medical record that in the opinion of a licensed medical practitioner a specified criterion or combination of specified criteria would cause the recipient severe harm in the event of a transfer. The requirement for documentation applies to all cases in which a continued stay at an inappropriate level is considered justified and is supplementary to any specific documentation requirements stated as a condition for the application of any particular factor listed below.

(A) Spouse Shares Room. Continued stay may be justified if spouses who share a room do not want to be separated. If only one spouse requires a different level of care, consideration should be given to a transfer to, or continued stay at, the higher level of care. If it is determined that both spouses are at an inappropriate level of care, maintaining the shared-room arrangement should be an important consideration in determining whether to recommend a transfer.

(B) Language Environment. If the recipient's communication skill in the English language is significantly limited and if current placement provides a compatible language environment that would not be available if the recipient was transferred to another facility, this may be a consideration when determining whether to recommend a transfer. However, if the transfer would be to a different level of care within the same facility, the language factor shall not be considered.

(C) Religious Dietary Environment. If the recipient's religious beliefs include dietary restrictions or dictates that are being met in the current facility and that could not be met if the recipient was transferred to another facility, this may be a consideration when determining whether to recommend a transfer. However, if the transfer would be to a different level of care within the same facility, the religious dietary factor shall not be considered.

(D) Frailty and Advanced Age. If the recipient is of advanced age and is diagnosed by his physician as physically frail, transfer may not be indicated if the recipient has resided in the facility for three or more years and if there is a documented history of adjustment problems and poor mental health status evidenced by such factors as chronic depression, social withdrawal, inappropriate hostility, verbally abusive behavior, or severe lethargy. If this factor is to be applied, there must be documentation in the recipient's medical record by the attending physician verifying that the recipient would be at risk medically if a transfer occurred.

(E) Mental Health Status. If the recipient has exhibited unstable behavior or adjustment problems, has recently lost a relative, or is participating in an organized treatment program to maintain or improve his mental health status, a decision to transfer him may be delayed for 30 days. During this time, if a licensed or certified mental health professional documents in the recipient's medical record that in his opinion a transfer will be harmful to the recipient's mental health, continued stay may be justified.

(F) Blindness. Although a recipient's blindness is not, in itself, a sufficient reason for not transferring him, it should be considered with all other factors involved in the transfer and in relation to the recipient's medical and psychosocial needs.

(G) Loss of Visitors. If the recipient is visited often and regularly by one or more relatives or friends and the location of the alternative facility would make it impossible for those relatives or friends to arrange public or private transportation to continue those visits, continued stay may be justified if there are no other relatives or friends who could visit him in the new location. If this factor is applied, the standard used must be the impossibility of continued visits, not merely inconvenience to the relatives or friends.

# INSTRUCTIONS FOR THE COMPLETION OF THE LONG-TERM CARE ASSESSMENT FORM

## I. INTRODUCTION

The Long Term Care Assessment Form consists of six sections labeled A through F. The major consideration in developing this form was to create an instrument that would promote an accurate assessment of the medical, physical, psychosocial and emotional needs of the client. This assessment serves as a basis for identifying the most appropriate arrangement and setting for meeting each clients needs, as it prompts consideration of both community based and institutional services. This form assures, to the greatest extent possible, consistency in the application of the Department's Level of Care Criteria (106 CMR 456.251 through 456.270). Each section of the form will be explained in this manual and definitions will be provided to promote clear understanding of the terms contained within the instrument.

## II. SECTION IDENTIFICATION

The form begins with the area in the upper left corner of page one provided for the TYPE OF REQUEST for approval. It is expected that the entire form will be completed for the following types of cases:

1.) Preadmission Request - for the Medicaid recipient or Medicaid eligible client who is currently in the hospital or residing in the community. It is requested that you specify the client's current setting.

2.) Preadmission Request - for the private pay client who requests a screening prior to entering a nursing home. It is requested that you specify the client's current setting.

3.) Conversion Request - is checked for clients in nursing homes who are converting from private pay status to Medicaid and did not have a Private Pay Consult by the Placement Review Team.

4.) Retrospective Review - is checked by the Placement Review Team when a post-admission review is conducted to verify the appropriateness of a placement.

5.) Short Term Review - is checked when the assessment is a follow-up to an initial short term approval by the Placement Review Team.

6.) C.C.C. ~~Frail Elderly Program~~ - is checked when the request is for eligibility screening for the Coordinated Health Frail Elderly Program.

7.) 2176 Waiver * - is checked when the request is for eligibility screening for non-institutional services provided under the 2176 Waiver.

8.) Pers/Respite Waiver - is checked when the request is for eligibility screening for these non-institutional waivered services.

9.) Other - is provided to accommodate any category of request not mentioned above.

COMPLETION OF ONLY SECTIONS A,B1,C,D, AND E of the Long Term Care Assessment Form is required for the following types of cases:

1.) Conversion Review - is checked if the client was previously screened as a Private Pay Consult by the Placement Review Team.

2.) Level Change/Hospital - is checked when the client was initially approved for a level of care, and due to a change in the client's condition a different level is being requested while the client is still hospitalized.

3.) Level Change/Community - is checked when the client was initially approved for a level of care and due to a change in the client's condition a different level is being requested while the client is still in the Community.

## SECTION A: DEMOGRAPHIC DATA

This information is essential, it must be complete and accurate in order to process a referral appropriately. The data collected in this section is necessary for proper client identification and to facilitate entry into the record-keeping and billing systems of the Department of Public Welfare. There are spaces provided for Medicaid and Medicare numbers as well as identifying the specific Long Term Care Unit where the client's Medicaid Application was filed. If a client is a non-recipient, please indicate " N/A " in the blank provided for the Medicaid number. If a number is unknown due to a new application, please indicate as such and provide the date it was sent to the LTCU.

The Date of AND Status is the date that a patient in the acute care setting began Administrative Day Status. If the patient is not on Administrative Day Status please indicate " N/A " in the space provided.

## SECTION B

This section contains three (3) subsections:

### 1.) REASON FOR REFERRAL & LEVEL OF CARE REQUESTED

Indicate the reason(s) for nursing home placement. Since this list is not exhaustive, an "other" (specify) blank is provided.

The Level of Care you request must be based on the criteria provided by the Department of Public Welfare (106 CMR 456.251 through 456.270). It is advised that you request Skilled Nursing Facility (SNF)/Level II for:

A. Clients who meet the criteria for skilled nursing services (456.253 and 456.254).

B. Clients who meet the criteria for skilled rehabilitation services (456.253 and/or 456.255).

C. Clients who require skilled management of an aggregate of services (456.253 and 456.256).

Intermediate Care Facility (ICF services/Level III should be requested for clients who meet the criteria 106 CMR 456.260 through 456.263.

Requests for either Level II or Level III may be for short term or long term placement. If the request is for short term approval, please indicate the goals that are being established for the client.

The assessment form also requests consideration of Level I placement if the client requires skilled nursing or rehabilitation care. This question ensures the consideration and/or exhaustion of Medicare/Level I benefits before Medicaid reimbursement is sought.

2.) CLIENT ATTITUDINAL ASSESSMENT

This section of the instrument is intended to identify clients who are motivated to remain in the communtiy. This information is important for determining the appropriate discharge plan and site. Please be sure to check all pertinent information since more than one item may apply.

3.) CLIENT LIVING ARRANGEMENTS

The list of possible living arrangements are grouped under "Current", indicating where the client is located at the time of referral (ex. acute hospital), and, "Usual", indicating where the client normally resides, (ex. Rest Home). There is also an item questioning the availability of the clients usual living arrangement. This information is used as an indicator for identifying the likelihood and appropriateness of continuation of previous living arrangements.

OTHER INFORMATION

This section can be used by clinicians to provide additional anecdotal information considered significant by the referral source to substantiate the requested level of care. Since the remainder of the instrument provides ample documentation for level of care determination, this section is optional.

## SECTION C: HEALTH DATA

- Primary Diagnosis:- Indicate major medical problem and/or current problem.
- Secondary Diagnosis: Indicate all other diagnoses.
- Under Treatment: Indicate after each diagnosis if client is currently receiving medical intervention/treatment for the specified condition or disease.
- Physician Name: Indicate primary physician who is responsible for client's current medical care plan. Include address, telephone number, and date of last visit.
- Comments: May include reason for hospitalization in past year: recent surgeries, etc.

## NURSING CARE AND THERAPIES (NURSING I AND NURSING II)

This section measures the clients' need for twenty-four hour skilled vs. intermittent care. The categories provide significant level of care indicators such as timing, self-care, and whether the client can be trained indicating possible community placement.

This section is to be completed according to physician orders.

Ex.#1 - If M.D. orders specifically direct intake and output monitoring, this should be indicated; however, if hospital or nursing home policy is to routinely monitor the Intake and Output of all patients, this should not be reflected on the form as this is not a client specific need.

Ex.#2 - Routine vital sign monitoring without rationale according to diagnoses and concommitant M.D. orders should not be checked. However, if the patient's condition warrants skilled monitoring based on vital sign results, as reflected in M.D. orders, it should be indicated on the form.)

## THERAPY SERVICES

Indicate if therapy is not ordered, or, if client is currently receiving service, check the "Receives" section and indicate the frequency of therapy. It is important to identify if therapy is skilled or maintenance; if skilled, estimate expected duration. Also, if client is hospitalized and currently receiving skilled therapy, indicate if this plan will continue after discharge. These comments may be indicated on page one in the section marked "Other Information" (Optional).

## SCORING

Indicate specifically for Nursing I, Nursing II, and Therapy whether client qualifies on this basis above for non-institutional care, ICF, SNF aggregate; SNF skilled, or chronic care (based on the level of care regulations).

Note: For definitions of all terms in Nursing Care and Therapies please see Attachment I.

## MEDICATION PROFILE

ADMINISTRATION: Indicate the response most reflective of client's abilities.

## CURRENT MEDICATIONS

List all significant medications, dose prescribed, route of administration; frequency administered; please check one of the last two boxes to indicate if a prescription is necessary for each medication or whether it can be obtained "over the counter" (OTC).

Note: If "medication monitoring" is checked in Nursing I section, the current medications indicated should reflect this need (i.e. Coumadin ~~may~~ require monitoring, whereas ASA may not).

Note: Medication monitoring refers to those medications requiring supervision/observation/monitoring by licensed personnel to evaluate side effects and possible need for medical intervention. Medications and diagnoses identified should be correlated. (Refer to Attachment I).

## MEDICATION SCORE

Using your clinical judgement, indicate whether the medications listed require "no monitoring", "interim or occasional monitoring", or are administered in "maintenance dose". If one medication is deemed "life threatening" this box should be checked. In this section only one box should be checked based on the overall medication profile (ex. if ASA, Colace, Lasix (maintenance dose), Comadin (maintenance dose) are listed, then "maintenance dose" should be checked even though ASA and Colace require "no monitoring.").

Indicate total score for Section C in the box provided.

## SECTION D

### ACTIVITIES OF DAILY LIVING

Complete this section using the definitions provided in Attachment II. For purposes of this section "unable" will also mean "totally dependent".

Bladder Control/Bowel Control - Indicate if client is:

Continent - no episodes of incontinence.

Occasionally Incontinent - three to four episodes of incontinence per week .

Incontinent - More than four episodes of incontinence per week or incontinent at all times.

Catheter/Colostomy - Refer to definitions contained in Attachment II.

Sight/Hearing/Speech - Indicate if senses are good, fair, poor or absent.

### INSTRUMENTAL ACTIVITIES OF DAILY LIVING

The client's ability to perform IADL's provides an indication of whether the client can return to or remain in the community with or without support services.

Complete this section according to client's ability to perform each function. (ex. is client able to initiate a telephone call independently or with assistance?). For purposes of this section, "partial physical" may also mean "use of adaptive devices" where appropriate.

Safety Alone - Indicate degree of concern with any situation which would affect client's ability to live alone (ex. frequent falls, unable to evacuate home in case of fire).

Neighborhood Safety - Indicate degree of concern with client's ability to reside in present neighborhood. (ex. can client safely leave home without fear)

Utilities - Indicate degree of concern prompted by status of utilities in client's home: Does client have heat, electricity, hot water, telephone, functioning toilet? Is client able to respond to problems with utilities?

Hazard Barriers - Indicate degree of concern with any barrier which would restrict the client's ability to move about freely and safely. (ex. stairways without railings; throw rugs ; exposed electrical wires).

TOTAL SCORE FOR SECTION D

Calculate the score for each box checked in this section and indicate the total in the box provided.

## SECTION E: EMOTIONAL AND COGNITIVE FUNCTIONING

This section is designed to assess a client's present sensorium in relation to the Department of Public Welfare's Level of Care Criteria. Section I is devided into five (5) subsections; each subsection must be completed and explanations given where requested. An overall score for each subsection should be tallied and be based on an overall clinical impression of the client's functioning. Please note that no one individual response constitutes a specific score; rather, the referral source assigns a numerical score to indicate an overall functional level of Very Good, Good, Fair, or Poor, within each subsection. For Example:

Motivation:

1. Does client exhibit enthusiasm toward regaining independence? X Yes ___NO
2. Does client require coaxing and encouragement to function to potential? ___Yes X No
3. Does client exhibit feelings of helplessness? ___Yes X No

| Very Good | Good | Fair | Poor |
|---|---|---|---|
| XX 0 | 3 | 6 | 10 |

Once each subsection is completed, a total numerical score should be obtained and recorded in the box labeled TOTAL SCORE FOR SECTION E.

Note: In an effort to promote consistency in application, the definitions of terms are provided for completing Section E in Attachment III

## SECTION F: CONSIDERATION OF COMMUNITY ALTERNATIVES

This section consists of two sub-sections, Informal Support System & Formal Support System.

The Informal Support System sub-section lists and measures the involvement of those caregivers who are available to the client for support and information. This section is also important in identifying appropriate referrals to Coordinated Health Programs and other Community-based Waivered Services as it helps to ascertain the potential for successful community placement.

The Formal Support System sub-section reflects the amount of community services that a client requires to remain in the community and whether or not the services are available, currently unavailable, or non-existent. This data is essential for documenting gaps in service availability and serves as a basis for developing a care plan.

The directions for completing the Formal Support System are provided on the form itself. Please follow these directions carefully and completely.

## SCORING

The purpose of scoring this form is to promote objective and consistent application of the instrument in determining the appropriate care setting for the client. Each section of the form is given a specific number of points which corresponds to the relative importance and weight of the particular section to the overall leveling decision. The point system is designed to create two measures of nursing home eligibility. The first measure is an unusually high score in any one of three sections and the second measure is a composite score of all sections. This scoring system is intended to promote consistent application of nursing home eligibility standards. Please indicate the numerical score for each section in the blank provided on the far right of the scoring section.

Definitions

Attachment I

NURSING CARE AND THERAPIES:

| | |
|---|---|
| Parenteral medications | Any medication given by subcutaneous, intramuscular, intradermal, intrasternal and intra venous route. |
| Medication Monitoring | The monitoring of oral or injectable medications that require the judgement and direction of a registered nurse to monitor the dosage and frequency and to observe the recipient for any adverse reactions to the medication. Drugs with life-threatening side effects, given as treatment for an acute condition, may require skilled nursing care, nor does a 24-hour medication regimen. |
| Parenteral Fluids | The use of the intravenous or subcutaneous route for the administration of fluids used to maintain fluids and electrolyte balance and/or nutrition. |
| Inhalation Therapy | The administration and/or teaching of techniques or use of equipment to increase plumonary capacity, liquefy secretions, and/or facilitate the exchange of gases at the Alveolar level. |
| Oxygen | The administration of oxygen by any method. |
| Suctioning | The use of suction equipment in any body cavity using clean or aseptic technique as appropriate. |
| Aseptic Dressing | The application of sterile dressing using aseptic technique. This also includes the application of medicated ointments, creams, sprays or solutions under sterile conditions to an open lesion. |
| Lesion Irrigation | The use of intermittent or continuous sterile or clean moist compresses or soaks, insertion of catheters or tubing into an open leison for removal of secretions or instillation of medication or debridement of necrotic material. |

Attachment I. Cont'd

| | |
|---|---|
| Decubitus treatment | A planned program to treat decubiti including regular periods for turning, application of medication and/or the use of special equipment. |
| Tube Feedings | The use of a nasogastric (including the insertion of) gastrostomy or jejunostomy tube for the insertion of fluids for hydration, nutrition, and medication. |
| Intake and Output | The monitoring of all fluid intake and output. |
| Isolation | Strict isolation whereby the patient is secluded in a private room to prevent the spread of communicable disease.<br>Reverse isolation attempts to protect the infection-prone patient from contact with potentially harmful microorganisms. |
| Catheter Irrigation | Insertion of catheter into the urinary bladder and the installation of fluid through the catheter for the purpose of cleansing or introducing medication into the urinary bladder using aseptic technique. |
| Ostomy Care | The care of a colostomy, ileostomy, ureterostomy, tracheostomy, gastrostomy, or any such opening including the care of surrounding skin, cleansing and observation of the stoma for patency, and the use of specialized equipment necessary to the maintenance of the ostomy. |
| Bowel/Bladder | A planned program to gain or regain optimum bowel and bladder function. |
| Vital Sign Monitoring | Monitoring of blood pressure, pulse, respirations, temperature when related to a specific diagnosis or treatment. |
| Heat Treatments | Administration of a hot pack, hydrocollator, infrared treatment or paraffin bath. |

Attachment II

## Definitions

ADL and IADL:

| | |
|---|---|
| Supervision/Encouragement | Verbal cueing or reminder to toilet as opposed to scheduling. |
| Partial Physical | The patient receives assistance from another person in getting to and from the bathroom, transferring on and off the toilet. |
| Unable/Dependent | The patient uses urinal, bedpan or commode with the assistance of another person. |
| Transfers-Independent | The patient receives no assistance or supervision from another person. |
| Supervision/Encouragement | guarding, guiding, protecting or supervising the patient in process of transfer. |
| Partial Physical | The patient requires active assistance of another person to transfer. |
| Unable/Dependent | means the patient is lifted out of bed, chair by another person or persons and does not participate in the process. |
| Feeding - Independent | The patient does not receive assistance of another person. |
| Supervision/Encouragement | The patient needs verbal cueing to feed. |
| Partial physical | Another person assists the patient in cutting food, pouring liquids, etc. |
| Unable/Dependent | The patient is fed by another person. |
| Bathing - Independent | The patient receives no assistance or supervision from another person. |
| Supervision/Encouragement | The patient requires reminder or encouragement to bathe. |
| Partial Physical | The patient requires the physical assistance of another person to bathe some parts of body (i.e., back, feet) and/or assistance getting in and out of tub. |

(12/84)

Attachment II Cont'd

| | |
|---|---|
| Unable/Dependent | The patient is bathed totally by another person. |
| Dressing - Independent | The person receives no assistance or supervision from another person. |
| Supervision/Encouragement | The person requires verbal cueing to dress and/or supervision while dressing. |
| Partial Physical | Another person helps the patient dress. |
| Unable/Dependent | The patient is completely dressed by another person/or cannot be dressed because he/she is bedridden. |
| Ambulation - Independent | Walks without the assistance of another person. With or without device. |
| Supervision/Encouragement | Walks with standby guidance of another person. |
| Partial Physical | Walks with the physical assist of another person. |
| Unable/Dependent | Unable to walk/or must require the assistance of two peopele. |
| Wheeling - Independent | The patient receives no assistance or supervision from another person and is independent in using the wheelchair. |
| Supervision/Encouragement | N/ |
| Partial Physical | Another person helps the patient in maneuvering wheelchair. |
| Dependent/Unable | Another person wheels the patient/ the patient is totally unable to manuver the wheelchair. |
| Stairs - Independent | The patient can negotiate stairs independently with or without device or supervision. |
| Supervision/Encouragement | The patient requires supervision on stairs with or without device. |

Attachment II Cont'd

| | |
|---|---|
| Partial Physical | The patient requires physical assist of another person to negotiate stairs. |
| Dependent/Unable | The patient is totally unable to negotiate stairs. |
| Catheter - Self-Care | The patient is independent in care of catheter (i.e., empty drainage bag; irrigate as necessary). |
| Needs Assistance | The patient needs some assistance with catheter care. |
| Unable | The patient requries total assist with catheter care. |
| Colostomy - Self-Care | The patient is independent in all aspects of colostomy care (i.e., emptying appliance, changing colostomy bag). |
| Needs Assistance | The patient needs some assistance with colostomy care (i.e., supervision in positioning of appliance). |
| Unable | The patient requires total assist with colostomy care. |

## IV Functional Impairment Levels

The revised priority category system is based on the functional impairment of the client rather than the need for Home Care Services.

The case manager shall determine a Functional Impairment Level for each client based on the Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

The following scale is used to measure ADLs:

0: Completely Able

1: Able with Aids/Difficulty

2: Able with Helper

3: Unable

A score of 2 or 3 = ADL Impairment.

The following scale is used to measure IADLs:

0: Without Help

1: With Some Help

2: Can't Do At All

A score of 1 or 2 = IADL Impairment.

The Functional Impairment Levels are:

Functional Impairment Level 1: 4-7 ADL Impairments
Functional Impairment Level 2: 2-3 ADL Impairments.
Functional Impairment Level 3: 6-10 ADL's and/or IADL's
Functional Impairment Level 4: 4-5 ADL's and/or IADL'S
Functional Impairment Level 5: 2-3 ADL's and/or I ADL's

To determine the appropriate level, the case manager shall count the number of ADL and IADL Impairments.

If a client has Two (2) or more ADL Impairments he/she will receive a Functional Impairment Level of One (1) or Two (2) regardless of the number of IADL Impairments.

## Long Term Care Connection

**Purpose:** The purpose of the Long Term Care Connection (LTCC) is to provide preadmission screening to indviduals contemplating nursing home placement. The goal is to ensure that community alternatives are realistically considered, such that nursing home placement is made, only when no community alternative exists.

- Preadmission screening is mandatory for all Medicaid eligibile clients seeking nursing home placement.

- Preadmission screening for private payors is voluntary, but strongly recommended.

**Staff:** LTC Connection sites are scattered across the Commonwealth, they are staffed by Registered Nurses. The Nurses' role is to review all requests for nursing home placement and determine a level of care. The nurse may also assess eligibility for special programs that make continued stay in the community easier to manage.

- The assessment could be a paper review or a visit with the client.

- As part of the assessment the nurse will review the client's medical, nursing, and psychosocial needs.

- The nurse might recommend continued stay in the community and assist the client in making community service arrangements, or may recommend nursing home care.

**Policies:** The Overriding policy of the LTC Connection is to maximize the appropriate utilization of Long Term Care services.

- The program staff work closely and cooperatively with the client, family members and professional care givers to insure the best possible plan for the client.

- The LTCC nurse can act as a resource to clients family, and other professionals.

### COMMONWEALTH OF MASSACHUSETTS
### DEPARTMENT OF PUBLIC WELFARE
### LONG TERM CARE ASSESSMENT FORM

Page 1

**PLEASE CHECK TYPE OF REQUEST**

Complete Entire Referral for the following Requests:

- __ Preadmission Request
  - __ Hospital __ Community
- __ Preadmission Request (Private Consult)
  - __ Hospital __ Community
- __ Conversion Request (Nursing Home Only)
- __ Retrospective Review
- __ Short-Term Review
- __ Community Care Connection
- __ 2176 Waiver
- __ Pers/Respite Waiver
- __ Other ____________

Complete Only Sections A, B1, C, D, and E of the Referral for the following Requests:

- __ Conversion Review (if previously LTCC screened)
- __ Level Change/Hospital
- __ Level Change/Community

Indicate if delegated hospital

__ Yes __ No

**SECTION A. DEMOGRAPHIC DATA**

Applicant Name: ____________
Address: ____________
Telephone: ____________
Date of Birth: ______ Age: ______
Sex: ______ Marital Status: ______
Next of Kin/Guardian: ____________
Address: ____________
Telephone Number: ____________
Relationship: ____________
Referring Source: ____________
Telephone Number: ____________
Other Data ____________
Social Security Number: ____________
Medicare Number: ____________
Medicaid Number: ____________
Date of AND Status: ______ LTCU: ______
Date of Hospital/Nursing Home Admission: ______

**SECTION B**

**1. REASON FOR REFERRAL**

- __ Change in functional status due to injury or sickness
- __ Behavioral/emotional problems
- __ Disorientation/confusion
- __ Current agency-provided service inadequate
- __ Temporary loss of caregiver
- __ Caregiver exhaustion
- __ Abuse or neglect: vulnerable adult
- __ Other (specify) ____________

____________

____________

____________

If seeking nursing home placement, what level of care is being requested:

- __ SNF, Level II ( __ Skilled __ Rehab __ Aggregate)
- __ ICF, Level III
- __ Goals: __ Short Term __ Long Term

____________

____________

Has Level I placement been considered? __ Yes __ No

**2. CLIENT ATTITUDINAL ASSESSMENT**

Client wishes to (check all that apply):

- __ Receive community services
- __ Refuse services
- __ Enter non-health care facility
- __ Remain in present living situation
- __ Enter health care facility
- __ Other (specify) ____________

____________

**3. CLIENT LIVING ARRANGEMENTS**

| Current | Usual | |
|---|---|---|
| ______ | ______ | Private residence alone |
| ______ | ______ | Private residence with others |
| ______ | ______ | Special housing for elderly/handicapped |
| ______ | ______ | Licensed boarding house |
| ______ | ______ | Foster care |
| ______ | ______ | Congregate housing |
| ______ | ______ | Rest home |
| ______ | ______ | Skilled nursing facility |
| ______ | ______ | Intermediate care facility |
| ______ | ______ | Chronic disease rehabilitation hospital |
| ______ | ______ | Psychiatric inpatient hospital |
| ______ | ______ | Acute hospital |
| ______ | ______ | Other (specify) ____________ |

____________

Are client's usual living arrangements currently available?

__ Yes __ No If no, when will they be available? ______

**OTHER INFORMATION** (Optional)

____________

____________

____________

____________

____________

____________

____________

____________

____________

Signed: ____________ Date: ____________

**Name:** ______________________________ **Page 2**

## SECTION C: HEALTH DATA (To be completed on all clients)

**Primary Diagnosis:** ____________________
**Secondary Diagnoses:** ____________________
____________________
____________________

| UNDER TREATMENT | |
|---|---|
| Yes | No |
| | |
| | |
| | |
| | |
| | |

**Physician Name:** ____________________
**Address:** ____________________
____________________
**Telephone Number:** ____________________
**Date of Last Visit:** ____________________

**Number of acute hospitalizations in last 12 months:** ____________ **Last Admission Date:** ____________ **Discharge Date:** ____________
**Comments:** ____________________
____________________

## NURSING CARE AND THERAPIES

(To be completed on all clients according to physician orders. If PRN, indicate timing.)

| NURSING I | Timing | | | # Per Shift | Self Care | | Train Patient? | | Train Caregiver? | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Day | Evening | Night | | Yes | No | Yes | No | Yes | No |
| Parenteral Meds | | | | | | | | | | |
| Medication Monitoring | | | | | | | | | | |
| Parenteral Fluids | | | | | | | | | | |
| Inhalation Treatment | | | | | | | | | | |
| Oxygen | | | | | | | | | | |
| Suctioning | | | | | | | | | | |
| Aseptic Dressing* | | | | | | | | | | |
| Lesion Irrigation* | | | | | | | | | | |
| Decubitus Treatment* | | | | | | | | | | |

*Site and Treatment: ____________________
____________________

| NURSING II | Timing | | | # Per Shift | Self Care | | Train Patient? | | Train Caregiver? | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Day | Evening | Night | | Yes | No | Yes | No | Yes | No |
| Tube Feedings | | | | | | | | | | |
| Intake and Output | | | | | | | | | | |
| Isolation | | | | | | | | | | |
| Catheter Tube Irrigation | | | | | | | | | | |
| Ostomy Care | | | | | | | | | | |
| Bowel/Bladder Training | | | | | | | | | | |
| Vital Sign Monitoring | | | | | | | | | | |
| Heat Treatments | | | | | | | | | | |
| Other | | | | | | | | | | |

| THERAPY SERVICES | Not Ordered | Receives | Frequency |
|---|---|---|---|
| Physical Therapy | | | |
| Speech Therapy | | | |
| Occupational Therapy | | | |
| Nutritional Therapy | | | |
| Medical Social Worker | | | |
| Mental Health | | | |
| Respiratory Therapy | | | |

| | Non-Inst | ICF | SNF Aggr | SNF Skilled | Chronic |
|---|---|---|---|---|---|
| NURSING I | 0 | 25 | 50 | 75 | 100 |
| NURSING II | 0 | 25 | 50 | 75 | 100 |
| THERAPY | 0 | 25 | 50 | 75 | 100 |

## MEDICATION PROFILE

**ADMINISTRATION:**

- ___ Client is able to take correct doses at the right time without assistance.
- ___ Client can prepare and take his/her own medications, but requires verbal reminding.
- ___ Client can take his/her own medications, but requires assistance with preparation and reminding.
- ___ Client is unable to take medications by self.

**Allergies:** ____________________
**Blood Pressure:** __________ **Date Taken:** __________ **Frequency:** __________
**Temperature:** __________ **Date Taken:** __________ **Frequency:** __________
**Pulse:** ________ **Resp:** ________ **Date Taken:** ________ **Frequency:** ________
**Diet:** ____________________
**Skin Condition:** ____________________
**Height:** ______________ **Weight:** ______________
**Pertinent Lab Work:** ____________________
____________________

**CURRENT MEDICATIONS:**

| Name | Dose | Route | Frequency | Prescription | OTC |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Note:** Indicate with an asterisk (*) those medications required during the 11 pm - 7 am period.

| | No Monitoring | Interim | Maintenance Dose | Life Threatening |
|---|---|---|---|---|
| MEDICATION SCORE | 0 | 5 | 15 | 30 |

**TOTAL SCORE FOR SECTION C:** ☐

**Signed:** ______________________________ **Date:** ______________________________

Name ______________________________

## SECTION D: ACTIVITIES OF DAILY LIVING

| | Indepen-dent | Support/ Encrgmt | Partial Physical | Unable |
|---|---|---|---|---|
| TOILETING | 0 | 5 | 10 | 15 |
| TRANSFERS | 0 | 5 | 10 | 15 |
| FEEDING | 0 | 5 | 10 | 15 |
| BATHING | 0 | 3 | 6 | 9 |
| DRESSING | 0 | 3 | 6 | 9 |
| AMBULATION | 0 | 2 | 4 | 6 |
| WHEELING | 0 | 2 | 4 | 6 |
| STAIRS | 0 | 2 | 4 | 6 |

Does client use any device(s)? Yes __ No __

If yes, identify: ______________________________

Is client bedbound? Yes __ No __

| | Con-tinent | Occl/ Incont | Incon-tinent |
|---|---|---|---|
| BLADDER CONTROL | 0 | 10 | 20 |
| BOWEL CONTROL | 0 | 10 | 20 |

| | Selfcare | Needs Asst | Unable |
|---|---|---|---|
| CATHETER | 0 | 15 | 30 |
| COLOSTOMY | 0 | 15 | 30 |

| | Good | Fair | Poor | None |
|---|---|---|---|---|
| SIGHT | 0 | 2 | 3 | 4 |
| HEARING | 0 | 1 | 2 | 3 |
| SPEECH | 0 | 1 | 2 | 3 |

### INSTRUMENTAL ACTIVITIES OF DAILY LIVING

| | Indepen-dent | Support/ Encrgmt | Partial Physical | Unable |
|---|---|---|---|---|
| MEDICATION ADMINISTRATION | 0 | 5 | 10 | 15 |
| MEAL PREPARATION | 0 | 1 | 2 | 3 |
| TELEPHONE | 0 | 2 | 3 | 4 |
| WALKING/INSIDE | 0 | 1 | 2 | 3 |
| TRAVEL/OUTSIDE | 0 | 1 | 2 | 3 |
| HOUSEWORK | 0 | 1 | 2 | 3 |
| SHOPPING | 0 | 1 | 2 | 3 |
| LAUNDRY | 0 | 1 | 2 | 3 |

| | No Problem | Some Concern | Serious Concern | Grievous |
|---|---|---|---|---|
| HAZARD BARRIERS | 0 | 1 | 2 | 3 |
| SAFETY ALONE | 0 | 1 | 2 | 3 |
| NEIGHBORHOOD SAFETY | 0 | 1 | 2 | 3 |
| UTILITIES | 0 | 1 | 2 | 3 |

TOTAL SCORE FOR SECTION D: ☐

## SECTION E: EMOTIONAL AND COGNITIVE FUNCTIONING

**MOOD AND EFFECT**

1. What is client's response to question, "How do you feel?" ______________________________
2. Is client alert? __ Yes __ No
3. Is client able to perceive/react to significant environmental stimulus? __ Yes __ No
4. Does client exhibit inappropriate affect? __ Yes __ No
5. Has client recently lost a relative or significant other? __ Yes __ No
6. Does client appear depressed? __ Yes __ No
   If yes, explain degree: ______________________________
7. Does client appear agitated? __ Yes __ No
   If yes, explain degree: ______________________________

| Very Good | Good | Fair | Poor |
|---|---|---|---|
| 0 | 3 | 6 | 9 |

**MENTAL HEALTH STATUS**

1. Is client oriented to person, place, and time? __ Yes __ No
2. Does client suffer from a significant memory loss? __ Yes __ No
3. Does client exhibit defective judgement? __ Yes __ No
4. Does client hallucinate? __ Yes __ No
5. Does client physically wander? __ Yes __ No
6. Is client participating in an organized treatment program to improve mental health status? __ Yes __ No

| Very Good | Good | Fair | Poor |
|---|---|---|---|
| 0 | 3 | 5 | 10 |

**RESPONSE TO ILLNESS**

| Accepting/Adaptive | Somewhat Accepting | Neutral/Passive | Denial/Unresponsive |
|---|---|---|---|
| 0 | 3 | 6 | 9 |

**BEHAVIOR**

1. Has client exhibited unstable behavior or adjustment problems? __ Yes __ No
2. Does client exhibit behavior that is detrimental to self or others? __ Yes __ No
3. Does client require restraints? __ Yes __ No
4. Does client exhibit chronic depression, social withdrawal, inappropriate hostility, verbally abusive behavior, or severe lethargy? __ Yes __ No
   If yes, specify: ______________________________
5. Does client exhibit bizarre actions? __ Yes __ No
   If yes, describe: ______________________________
6. Does client have a history of careless smoking? __ Yes __ No
7. Has client had a history of alcoholism or drug abuse? __ Yes __ No If yes, is it a potential problem in the community? __ Yes __ No

| Very Good | Good | Fair | Poor |
|---|---|---|---|
| 0 | 3 | 5 | 10 |

**MOTIVATION**

1. Does client exhibit enthusiasm toward regaining independence? __ Yes __ No
2. Does client require coaxing and encouragement to function to potential? __ Yes __ No
3. Does client exhibit feelings of helplessness? __ Yes __ No

| Very Good | Good | Fair | Poor |
|---|---|---|---|
| 0 | 3 | 6 | 10 |

TOTAL SCORE FOR SECTION E: ☐

Signed: ______________________________ Date: ______________________________

Name: ____________________ Page 4

## SECTION F: CONSIDERATION OF COMMUNITY ALTERNATIVES

### INFORMAL SUPPORT SYSTEM

1. List all family members, neighbors, friends, or other volunteers providing care in the home. If none, so state.

| | Name | Telephone | Relationship | Days/Hours Available | Task(s) Performed |
|---|---|---|---|---|---|
| A. | | | | | |
| B. | | | | | |
| C. | | | | | |

2. Family Support Status (answer in relation to family members with whom client is living and for family or friends who provide support as listed above.)

A. Motivated to keep client at home. ___ Yes ___ No
B. Capable of providing care. Physically: ___ Yes ___ No Emotionally: ___ Yes ___ No
C. Will keep client home if not involved in care. ___ Yes ___ No
D. Will keep client home if support services provided. ___ Yes ___ No
E. Requires instructions to provide needed care to client ___ Yes ___ No

| | | | | |
|---|---|---|---|---|
| | > 3 | 2-3 | 1-2 | None |
| NUMBER OF SUPPORTS | 0 | 2 | 4 | 6 |
| | Often | Occasionally | Emergency Only | Never |
| FREQUENCY OF INVOLVEMENT | 0 | 2 | 4 | 6 |
| | Able to Provide Full Care | Able with Direction or Instruction | Able with Support | Unable or Unwilling |
| POTENTIAL FOR CAREGIVING | 0 | 5 | 10 | 15 |

TOTAL SCORE FOR SECTION F: ☐

### FORMAL SUPPORT SYSTEM

Please complete the chart below, indicating which services would be needed to maintain the client in the community. For each service checked in the far left column, indicate whether that service is available, currently unavailable, or non-existent by placing the letters A, U/A, or N/E where called for in the chart and circle the frequency required.

| SERVICE (Check if needed) | | TIME OF DAY (Check Time(s)) | | | | | FREQUENCY (Circle Amount Needed) | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Morning 7-12 | Aft. 12-5 | Evening 5-11 | Night 11-7 | Week-Ends | | | | |
| | Nursing Service | | | | | | Visits/wk: | 1-2 | 3-4 | 5 + |
| | H.H.A | | | | | | Hours/wk: | 1-9 | 10-19 | 20 + |
| | Homemaker | | | | | | Hours/wk: | 1-5 | 6-11 | 12 + |
| | Adult Day Care | | | | | | Days/wk: | 1-2 | 3-4 | 5 + |
| | Meals on Wheels | | | | | | Meals/wk: | 1-4 | 5-9 | 10 + |
| | Companion | | | | | | Hours/wk: | 1-7 | 8-14 | 15 + |
| | Other | | | | | | | | | |

| OTHER SERVICE (Check if needed) | | AVAILABILITY (Check One) | | |
|---|---|---|---|---|
| | | Avail. | Curr. Unavail. | Non-exist. |
| | Foster Care | | | |
| | Respite Care | | | |
| | Mental Health | | | |
| | Rest Home | | | |
| | Elderly Housing | | | |
| | Congregate House | | | |
| | Other | | | |

### SCORING

| | Non-Institutional | ICF | SNF Aggregate | SNF Skilled | Chronic | SCORE |
|---|---|---|---|---|---|---|
| SECTION C: HEALTH DATA | | | | | | ______ |
| SECTION D: DAILY LIVING | | | | | | ______ |
| SECTION E: COGNITIVE FUNCTIONING | | | | | | ______ |

| | Non-Institutional | ICF | SNF Aggregate | SNF Skilled | Chronic |
|---|---|---|---|---|---|
| COMBINED: C, D, E | | | | | |

Signed: ____________________ Date: ____________________

10M-1/85-880271

Client Name ______________________________

ID # ______________________________

## SECTION C: ACTIVITIES OF DAILY LIVING

2 or 3 = ADL Impairment

# of ADL Impairments ________________

**☑ Home Care Intervention** — **How Does Client Usually: (Circle One)**

NARRATIVE:

☐ 1. Bathe

- 0 Completely able
- 1 Able with aids/difficulty
- 2 Able with helper
- 3 Unable

☐ 2. Dress/Undress

- 0 Completely able
- 1 Able with aids/difficulty
- 2 Able with helper
- 3 Unable

☐ 3. Eat

- 0 Completely able
- 1 Able with aids/difficulty
- 2 Able with helper
- 3 Unable

☐ 4. Toilet

- 0 Completely able
- 1 Able with aids/difficulty
- 2 Able with helper
- 3 Unable

☐ 5. Continence

| Bladder | Bowel |
|---|---|
| 0 Complete control | 0 |
| 1 Self care devices, no accidents | 1 |
| 2 Helper, occasional accidents | 2 |
| 3 Incontinent | 3 |

☐ 6. Transfer In/Out Bed/Chair

- 0 Completely able
- 1 Able with aids/difficulty
- 2 Able with helper
- 3 Unable

☐ 7. Get Around Inside

- 0 Completely able
- 1 Able with aids/difficulty
- 2 Able with helper
- 3 Unable

PERSONAL CARE MODULE: YES NO

Client Name ______________________

ID # ______________________

## SECTION D: INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1 or 2=IADL Impairment

# of IADL Impairments ________

☐ Home Care Intervention — Describe What Client Can Do. (Circle One)

☐ 1. Meal Preparation
- 0 Without help
- 1 With some help
- 2 Can't do at all

☐ 2. Housework
- 0 Without help
- 1 With some help
- 2 Can't do at all

☐ 3. Laundry
- 0 Without help
- 1 With some help
- 2 Can't do at all

☐ 4. Shopping
- 0 Without help
- 1 With some help
- 2 Can't do at all

☐ 5. Taking Medicine
- 0 Without help
- 1 With some help
- 2 Can't do at all

☐ 6. Get Around Outside
- 0 Without help
- 1 With some help
- 2 Can't do at all

☐ 7. Transportation
- 0 Without help
- 1 With some help
- 2 Can't do at all

☐ 8. Money Management
- 0 Without help
- 1 With some help
- 2 Can't do at all

☐ 9. Use Telephone
- 0 Without help
- 1 With some help
- 2 Can't do at all

NARRATIVE:

HOME DELIVERED MEALS MODULE: YES NO

## ACTIVITIES OF DAILY LIVING

### Section C

The client's physical, emotional, and cognitive status provides pertinent information about a client's well being. However, this information does not describe the degree of independence an individual can attain regardless of physical health. Case managers require specific information regarding the activities a client can perform in order to arrange for home care services which enable the client to remain at home.

This section allows the case manager to determine the level of impairment a client is experiencing, based on specific medical emotional or cognitive status. It is based on standard scales which have been tested and validated in programs serving the elderly. Substantial professional consensus exists regarding the validity of this series of questions.

The questions measure the degree to which a client can perform various tasks that are essential to independent living. These tasks, called Activities of Daily Living (ADLs), include: bathing, dressing/ undressing, eating, toileting, continence, transfer in/out of bed or chair, and indoor mobility.

The scale used to measure independence in ADLs uses ratings from 0 to 3. A score of zero represents complete independence (no impairment), while 3 represents complete dependence (impairment). Each item measures the level of impairment of the client, regardless of how much help they might be receiving at present. In administering the section, the case manager should circle the number which best corresponds to the client's impairment level. The following general definitions shall determine the ratings.

Information on each of the ADLs can be collected by observation, by direct questioning of the client, or by interview with a significant other. Case managers will want to know how the client usually performs a task, i.e., most of the time. Clients who have occasional difficulty should be coded based on their usual performance. However, occasional difficulties should be noted in the narrative section of the ADL page.

Barthel Scale Scoring (as defined by C.V. Granger, July, 1974)

0: Completely Able - Activity completed under ordinary circumstances without modification, and within reasonable time.

1: Able with Aids/Difficulty - Activity completed with prior preparation or under special circumstances, or with assistive devices or aids, or beyond a reasonable time.

2: Able with Helper - Activity completed only with help or assistance, or under supervision for safety, or by cuing. ANOTHER HUMAN IS INVOLVED IN ACTIVITY but client performs at least half the effort him/herself.

3: Unable - Client assists minimally (less than half of effort), or is totally dependent.

A SCORE OF 2 OR 3 ON THE ADL PAGE INDICATES AN IMPAIRMENT. A line is provided in the top right-hand corner to indicate the number of ADL impairments (count the number of times 2 or 3 was circled for each of the 7 ADLs).

NARRATIVE: In the narrative, list the following information, if applicable:

- the kind of aid the client uses, (e.g., a grab bar or stool for bathing)
- the kind of help they are receiving, (e.g., preparing the bath, washing back and feet, complete bed bath)
- who provides help

Narrative notes can be numbered 1 to 7 to correspond to the number of the ADL items, and consequently, do not need to be written directly opposite the corresponding item. Problems the client is experiencing which do not meet the definitions, but which are related to the ADL items, should be noted in the narrative.

Since the ADL scale and IADL scale which follows will be used in determining a client's functional impairment level, standard definitions for each ADL item are as follows:

1. BATHE

This item measures the client's ability to bathe or shower him/herself independently.

0: Client is able to prepare and take a bath or shower independently (including sponge baths) within a reasonable time.

NOTE: If the only help a client requires is help with shampooing, score this item "0". Many elderly persons require help with shampooing but this scale does not include shampooing. The need for help with shampooing shall be recorded in the narrative.

1: Client requires the use of equipment (i.e., tub stool, grab bars, or handle bars) to bathe or shower him/herself. Small items such as mitten wash cloths, long-handled brushes or non-slip soap dishes are not considered special equipment.

2: Client needs another human to assist him/her through this activity. This may include supervision for safety or cuing. Able with Helper will be circled if the client performs at least half the effort him/herself.

3: Client is unable to assist or assists minimally (less than half the effort) or is totally dependent on another human to complete the activity.

**NARRATIVE:** The case manager shall record the following information in the narrative:

- -Does the client take showers, baths, or sponge baths?
- -Type of equipment used, if any. Any problems with equipment?
- -Who helps with bathing? How often? Type of Assistance?
- -Is client able to bathe as frequently as needed?

2. **DRESS/UNDRESS**

This item measures the client's ability to dress or undress which includes: getting clothes from closets and drawers, putting them on, and managing fasteners such as buttons, snaps, hooks, or zippers. Dressing does not include tying shoes.

0: Client is able to dress independently within a reasonable amount of time.

1: Client uses aids such as zipper pulls and specially designed clothing (e.g., velcro fasteners) or requires an inordinate amount of time to do so.

2: Client needs another human to assist with dressing and performs at least half the effort.

3: Client is totally dependent or provides less than half the effort in dressing.

**NARRATIVE:**

- Type of help a client is getting, who assists?
- Type of equipment?
- Are arrangements satisfactory?

3. **EAT**

This item refers to the client's ability to feed him/herself including cutting meat and buttering bread. It does not refer to meal preparation. (This is covered in Section D.)

0: Client is able to eat independently within a reasonable amount of time.

1: Client uses special grip utensils or plates or client takes a inordinate amount of time to eat.

2: Client performs at least half the effort required to eat, but receives some assistance from another human.

3: Client performs less than half the effort.

**NARRATIVE:**

- Note aids client uses
- Who helps, which tasks?
- Need for equipment or assistance?

## TOILETING AND CONTINENCE

This item is particularly important because individuals who have difficulty with toileting and are incontinent are at a greater risk of institutionalization. Some case managers may feel uncomfortable asking clients about toileting and continence. However, many elderly individuals are accustomed to questions like this particularly if they have ever been hospitalized. It is important that the interviewer be matter-of-fact and cover these items as directly as any other item.

## 4. TOILET

This item deals with the client's ability to get to the bathroom, get on/off the toilet, clean him/herself, manage clothes, and flush.

0: Client is able to complete this activity independently or the client uses a urinal, bedpan or commode at night only and manages without assistance (including emptying the device).

1: Client uses grab bars, raised toilet seat or transfer board or client takes an inordinate amount of time.

2: Client requires human assistance in completing the activity but performs half the effort.

3: Client performs less than half the effort.

**NARRATIVE:**

- Note who the helper is and the extent of assistance.
- Type of equipment.

## 5. CONTINENCE

Incontinence may have one of several different causes, including specific disease processes, side-effects of medications, and functional difficulty (i.e., inability to reach the bathroom in time to avoid accidents - usually due to poor mobility). Clients with incontinence can often benefit from a medical evaluation to determine whether the condition can be remedied.

In order to obtain information regarding bowel and bladder continence, a case manager can ask a client, "Do you ever accidentally wet or soil yourself?" or "Do you ever have any accidents?"

Scoring categories for the bladder and bowel continence question vary slightly from other ADL items, but follow the same general pattern.

The following guidelines, taken from the Barthel self-care rating scale, shall be used in rating continence.

BLADDER

0: Complete Control. Complete voluntary control of the bladder; never incontinent.

1: Self-care Devices, No Accidents. Client has a catheter or other urinary drainage device. Client is able to empty, clean, and manage the use of the device without assistance. Client has no accidents.

2: Helper. Occasional accidents. Client needs assistance with a device, or has occasional accidents (with or without a device).

3: Incontinent. Cannot control urinary flow, despite aids or assistance.

BOWEL

0: Complete Control. Complete voluntary control of bowels; never incontinent.

1: Self-care Devices, No Accidents. Requires stool softeners, suppositories, laxatives, or enema, but does not require assistance, or has colostomy, but can manage device without assistance. No accidents.

2: Helper, Occasional Accidents. Requires assistance with devices, medications, enemas, etc., or has occasional accidents.

3: Incontinent. Client cannot control bowels despite aids or assistance.

Case managers should circle the appropriate rating (0-3) for both bladder and bowel continence.

NARRATIVE:

- Type of device. How long? Any problems?
- Who helps?
- Tasks performed by helper.
- Any problems?

## 6. TRANSFER IN AND OUT OF BED OR CHAIR

This item measures the level of personal assistance the client needs in transfers.

0: Client is able to transfer independently within a reasonable amount of time.

1: Special equipment is used in transfers such as lifts, hospital beds, sliding boards, "trapezes" or pulleys or client takes an inordinate amount of time to transfer in and out of the bed or chair.

2: Client who is supported in getting in/out of bed/chair or performs half the effort.

3: A client who must be lifted in/out of bed/chair.

**NARRATIVE:**

- Types of aids.
- Who is helping, tasks performed?

7. **GET AROUND INSIDE**

This item measures a client's indoor mobility. A case manager may ask a client, "How do you usually get around inside?"

0: Client is able to get around inside independently within a reasonable amount of time.

1: An aid such as walker, wheelchair, cane, crutches, or furniture is used to get around.

2: Client needs human assistance to get around.

3: Bedbound client.

**NARRATIVE:**

- Types of aids.
- Who is helping, tasks performed?

**NEEDS**

This section may uncover information which indicates the need for:

- medical, PT or OT evaluation and treatment
- nursing evaluation and care
- personal care, homemaker, home health aid
- health education in the use of devices or aids
- purchase, rental, installation, or repair of special equipment.

**HOME CARE INTERVENTION**

For each ADL item, a box is provided for Home Care Intervention. If the specific activity creates a need for a Home Care service, the box shall be checked (✓). For example, Bathe: "Able with Helper" and a personal care homemaker has been authorized.

If the situation calls for a simple referral to another agency, Home Care Intervention should not be checked (✓). This shall be noted in the Narrative or the Progress Notes. For example, if the impairment requires intervention by a CHHA and the action taken by the case manager involves a telephone referral, Home Care Intervention should not be checked (✓).

MODULE: A space is provided at the end of this section to indicate if the Personal Care Module has been completed.

This module collects additional information from all clients receiving Personal Care.

NOTE: If a Personal Care Module is completed, it is not necessary to duplicate information on the Narrative side of the ADL page.

## INSTRUMENTAL ACTIVITIES OF DAILY LIVING

### Section D

This section deals with a client's ability to carry out tasks which may not need to be done everyday (like ADLs), but which nevertheless are essential for living independently. Intervention may be required to help a client adapt to difficulties he/she may be experiencing in performing IADL activities. IADL items include meal preparation, housework, laundry, shopping, taking medicines, getting around outside, transportation, money management, and telephone use. Performance of some IADL items requires mental as well as physical capacity. For example, taking medications and managing money require memory, judgement, and intellectual ability. In addition, depressed clients tend to be less likely to neglect ADL activities than IADL activities such as cooking and cleaning. The IADL scale, therefore, measures the functional impact of emotional, intellectual, and physical impairments. A relationship exists between ADL and IADL impairments. Many clients who are independent in ADLs have IADL impairments. Most clients with ADL impairments have IADL impairments.

Not all clients have the opportunity to perform IADL tasks. For example, a client who lives with a relative or spouse might not prepare meals simply because another person routinely does this task. Similarly, some clients do not manage their own money because a spouse does it. However, the IADL scale is designed to measure a client's ability to perform these tasks, regardless of the individual's opportunity to perform them. Thus, in asking client's about IADL tasks, case managers must stress ability: "Can you prepare meals, do housework, shop, etc?"

Like ADL ratings, the case manager can obtain information regarding IADL impairments by observation, interview with family or friends, or by direct self-report of the client. The scale used to rate each IADL task differs slightly from the ADL scale. It includes three basic categories of functioning:

0: Without help. Client is able to perform task independently, without supervision, reminder or assistance.

1: With some help. Client is able to perform task only with some assistance, reminder or supervision.

2: Can't do at all. Client is not able to perform task at all, even with assistance.

1. MEAL PREPARATION

The case manager may ask the client, "Can you prepare your own meals?" Regardless of whether the client actually does prepare meals, ask whether he/she can.

0: Client is able to prepare and cook meals or client does not usually cook but is able to.

1: Client needs some assistance from another person, i.e., client is unable to prepare a meal but is able to reheat a prepared meal.

2: Client is unable to prepare or cook meals.

NARRATIVE:

- Who helps with preparation?
- Frequency and type of assistance.
- Reason for inability to cook.

2. HOUSEWORK

The case manager might ask the client "Are you able to do light housework (such as dusting, washing dishes)?" and "Are you able to do heavy housework (such as washing floors)?" Again, be sure to stress ability rather than actual performance.

0: Completely able.

1: Client can do light housework, but not heavy housework.

2: Client can not do light or heavy housework.

NARRATIVE:

- Who helps with housework?
- Frequency and type of assistance (i.e., family does spring cleaning)
- Why is the client unable to do housework? (i.e., severe arthritis or cognitive problem.)

3. LAUNDRY

The case manager might ask the client, "Are you able to do your laundry by yourself or do you need help?" (If the client lives with others and does not do his/her own laundry, be sure to ask whether he/she could do laundry.) Do not include Transportation to the laundry facilities as help with laundry. (This is covered in Item 7, Transportation.)

0: Completely able to do laundry.

1: Requires some assistance (i.e., facility is in the basement and a family member carries the laundry up the basement stairs).

2: Client cannot do laundry at all.

NARRATIVE:

- Who helps with laundry?
- Frequency of assistance.
- Note where laundry facilities are located (i.e., in home or laundromat.)

4. SHOPPING

This includes help with grocery shopping and errands; it does not include transportation to and from the store. It is important to determine whether the client would be able to shop by themselves, regardless of whether they currently have help with shopping.

0: Client is able to shop but needs help with transportation (note this in Item 7: Transportation).

1: Client needs some assistance (i.e., carrying bundles).

2: Client is unable to shop.

NARRATIVE:

- Who helps with shopping?
- Frequency of assistance.
- Also note proximity of shopping facilities.

5. TAKING MEDICINE

Taking medicine by one's self is defined as: remembering to take medicine; getting the medicine; measuring the proper amounts; actually swallowing the pill; applying the ointment; or giving oneself injections.

0: Completely able including giving injections.

1: Client needs assistance (i.e., reminder or RN to give injection).

2: Client is unable (either physically or cognitively unable).

NARRATIVE: If a client cannot take his/her own medicine, it is important to ask the reason and record this in the narrative. For service planning purposes, a client who forgets to take medications may require different types of services and supports than a client who is physically unable to take medication.

- Who helps with medicine?
- Frequency of assistance.

### 6. GET AROUND OUTSIDE

This item refers to the client's ability to move around outside, to walk or get around by some other means (i.e., wheelchair), and to do so without assistance.

0: Client is completely able to get around outside (even if he/she uses a wheelchair/walker).

1: Client requires an escort to push a wheelchair, hold his/her arm or to assist in event of disorientation.

2: Client is completely unable to go outdoors due to physical or mental disability.

NARRATIVE:

- Who helps?
- How often does client get outside.

### 7. TRANSPORTATION

This item measures a client's ability to use transportation. For this question only, ability to use transportation includes access to a means of transportation, as well as physical and mental ability.

Note: When giving a rating for transportation, rate client access without considering transportation provided to that client by the Home Care Corporation.

0: Client is completely able to travel in a car, bus, or senior van without assistance and has access to at least one of these methods on a regular basis.

1: Client needs assistance arranging for or using transportation either due to mental/physical impairment or has limited access.

2: Client is completely unable to travel. This type of client is usually severely impaired and requires occasional specialized or medical transportation to doctor's appointments.

NARRATIVE:

- Who helps with transportation?
- Frequency.

### 8. MANAGEMENT OF MONEY

This item refers to the client's ability to keep track of whatever money he/she has and includes; paying bills, writing checks, handling cash transactions, and making change.

Some clients may have a guardian, conservator or representative payee.

Legal Guardian is a legal device imposed by a court to provide protection of the estate (i.e., the property) and person of an individual.

Conservatorship is a form of guardianship which relates to a guardianship of property only.

Representative Payee refers only to a person who agrees to receive Social Security payments on behalf of another.

0: Client is able to manage his/her money independently.

1: Client cannot write checks and pay bills without help, but makes day to day purchases and handles cash.

2: Client has a legal guardian or conservator or client is unable to manage money.

NARRATIVE:

- Explain why client has conservator, payee or guardian.
- How long has this arrangement been in effect.

9. USE TELEPHONE

This item refers to the client's ability to use the telephone, including getting telephone numbers and placing calls by him/herself.

Special equipment in common use includes:

- amplifiers for people with speech and hearing impairments;
- enlarged dials or number stickers for the visually impaired;
- modified telephones for those with hearing aids;
- telephones hooked up to teletypewriters for those with speech impairments.
- signals (tone ringers, loud bells or lights) to indicate that the telephone is ringing.
- speaker telephones and head sets for clients who cannot hold receivers.

The case manager shall note any special equipment and code the answer based on his/her ability to use the telephone with special equipment.

If a client has no telephone, ask about his/her ability to use a telephone elsewhere (i.e., at a neighbor's home).

0: Client is completely able.

1: Client requires some assistance (i.e., someone else must dial).

2: Clients who cannot answer the telephone or dial the operator in an emergency.

**NARRATIVE:**

- Types of equipment.
- Who provides help?

**MODULE:** A space is provided at the end of this section to indicate if the Home Delivered Meal's Module has been completed.

This module collects additional information from all clients receiving Home Delivered Meals.

**HOME CARE INTERVENTION:** For each IADL item a box is provided for Home Care Intervention. If the activity creates a need for a Home Care service the box should be checked (✓). For example, Transportation; "Can't do at all" and Transportation is provided by the Home Care Corporation.

If the situation calls for a simple referral to another agency, Home Care Intervention should not be checked (✓). For example, Transportation "With some help" and client is referred to the local COA for transportation (usually involves 1-2 calls). This shall be recorded in the Narrative or the Progress Notes.

Chairman **Stark**. Now, that is the easy part.

The next part is, and I am sure you are also aware of this, that it might be very easy for a particular provider to provide this set. You could insulate us a little bit from the shock that we will get right after we even discuss with anybody this set by outlining where you see the various political pressures in that set. Because that usually has nothing to do with the care of the patients; I mean, everybody has decided that their particular act is the surgical instrument of choice at the particular time. I have yet to see an advocate for any group come before us and say we ought to provide care by the other group. That day has yet to come.

So that will most likely be the problem with any good definitional outline that you could provide, but if you could give us some hints as to who is on what side of these definitional issues, that too would be useful. I am sure other members would like to see which of their constituents they are making happy and unhappy if they show any interest in what you are providing us.

Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

Mr. Vladeck, I am impressed by the degree of private sector involvement in the financing of long-term care not only in this country, but in other countries and in societies very different from our own. The extent of the data that I have been able to get a hold of, a 50-50 division seems to be relatively common around the world. That is pretty close to where we are now, which leads me to this question:

Do you think it is possible for us to come up with a better balanced program for the elderly in terms of the location of health care with more sensible distinctions between acute care and long-term care, and still have, let us say, a 50-percent private sector involvement in the financing?

Mr. **Vladeck**. Let me say one thing, Mr. Gradison, that is a partial answer to your question. In fact, as you know, every year many hundreds of thousands of older citizens spend down to Medicaid eligibility because of use of nursing home services. What we essentially have in that situation is one in which you have a kind of catastrophic insurance with a 100-percent copayment, until you spend all your money, and then zero copayment thereafter.

It seems to me you might be able to preserve the 50-50 split. Some of that, of course, you can do if you have better private insurance, but I suspect many of the potential long-term care clients do not have the disposable income at that point in their lives when they are worried about it to buy the private insurance.

I think we might well think about ways to move Medicaid away from its zero and then 100 percent mechanism, keep the same split of public and private in the aggregate, but perhaps have a less abrupt impact on a number of families and less of a serious notch problem in many communities.

We have a lot of folks at 110 or 120 or 130 percent of the eligibility levels in the community who do not qualify for Medicaid-paid home care who really do not have the resources to buy it privately. And those are the folks who are out in the cold until they exhaust their assets.

If we had an 80-percent copayment or something, you might keep the same aggregate balance over time of public and private resources with a much better effect on the population.

Mr. Gradison. Thank you. Thank you, Mr. Chairman.

Chairman Stark. Mr. Pickle.

Mr. Pickle. I do not have any questions. It just seems to me like you are saying that, with all the problems we have in this area, the best money we could spend now would be for HCFA to conduct some demonstration projects in the next year or two.

Is that essentially your recommendation?

Mr. Vladeck. I think that would be very valuable. We had a lot going on in 1981, 1982 before OMB got real nervous about demonstrations, and a lot of promising stuff ready to go that just got stalled in its tracks. If we are not going to legislate a comprehensive program in the next year or two, it would be a pity to continue to leave all that stuff in the pipeline.

Mr. Pickle. I thank you.

Chairman Stark. Mr. Chandler.

[No response.]

Chairman Stark. Mr. Gregg.

Mr. Gregg. Do you have an estimate? You said hundreds of thousands of people are spending down the Medicaid levels. Do you have a number on that?

Mr. Vladeck. We do not have a direct number. We can infer a number from some GAO studies which suggest that over time about two-thirds of the Medicaid covered nursing home residents did not enter facilities as Medicaid recipients, but spent down after admission to the facilities. We are running just over a million admissions per year to nursing homes for the elderly.

Medicaid is paying on any given day probably—this is the fuzziest number, actually—for three-quarters or so of those. So you multiply out, and you come out to somewhere between half a million and three-quarters of a million folks who spend down annually. But we do not have a direct number.

Mr. Gregg. That becomes, then, the target group? The people who do not spend down appear to have the assets to survive the system as it is presently structured?

Mr. Vladeck. Depending on how long they live, yes.

Mr. Gregg. Right. So most of what you are talking about is how to deal with that target group that annually spends down?

Mr. Vladeck. No. In the target group that annually spends down, yes, sir. I think that is the place where the greatest inequities occur, where the greatest public anxiety is involved, and where people in transit between one coverage status and another often encounter the most serious difficulty getting services they need.

Mr. Gregg. And I guess I was not clear. How do you address the issue that when you approach this question through your increased copayment that you may draw a lot of people into the system that are not already in the system? Aren't you going to significantly increase costs by adjusting the situation so that you do not have to spend down?

Mr. Vladeck. Well, again, I think the critical issue, as it is with the Medicare issue—and we have not tested it at the Federal level, although the States are gaining additional experience—is how you can define a set of need for service criteria that can be determined relatively objectively and relatively reliably. And I think the cut has got to be not purely through some financial formula, but through some definition of relative need.

I think increasingly we have the sophistication to say folks who score over *x* in terms of the degree of disability or the amount of trouble they have getting around or how ill they are ought to be eligible for this; and folks who do not are left to private resources. I think increasingly we know how to do that.

Mr. GREGG. In the financial need area, though, that was not part of your calculation there, are you going to include assets as income?

Mr. VLADECK. Well, I think at the moment, for the folks most at risk for spend-down, you can both talk about a relatively low income eligibility level that covers a very large number of elderly persons; and if you have some reasonable assets test just to exclude the very affluent people who have no cash without getting into a big bureaucratic mess, then there is no reason not to include some kind of assets test as well.

Mr. GREGG. How do you get around the problem of people transferring assets in order to get into the benefit group?

Mr. VLADECK. You have created the problem of transferring assets by the mechanics of Medicaid eligibility. Again, what you have said to people is, as long as you have assets and income greater than *x*, we will not pay a nickel. As soon as your assets and income fall below *x*, we will pay 100 percent.

As long as you have that sort of notch, I do not believe you will effectively enforce against rational estate planning. I think it is the irrationality of that mechanic that generates the problem, and I do not think thereafter that any degree of enforcement effort is ever going to catch up with it.

Mr. GREGG. So you think that assets should not be accounted for?

Mr. VLADECK. No, I think they should, but I think we have to get away from this all or nothing subsidy kind of idea. Otherwise, people will continue to divest assets in more and more subtle ways.

Mr. GREGG. And what standard are you going to use?

Mr. VLADECK. For the assets?

Mr. GREGG. Right.

Mr. VLADECK. I honestly do not know. I assume you set it at some point where CBO tells you that you are covering a large fraction of people in need without either subsidizing very affluent people or busting your budget. But where exactly that number is, I think is a policy and political judgment and economic judgment. It is not a scientific or abstract judgment of any sort.

Mr. GREGG. That presumes that the vast majority of people who are going on Medicaid today are avoiding the obligation of using up their assets before they go on and are instead transferring out those assets.

Mr. VLADECK. No, I do not believe that is the case. The vast majority of people going on Medicaid today for long-term care have relatively limited assets and have already spent a very significant amount of their own and their family's resources before they qualify for Medicaid eligibility.

Again, if you look just at the aggregate numbers on distribution of income and assets among the elderly, and then translate that over to the long-term care population, I think you are in a misleading exercise; because those who are most in need of long-term care are not average over 65 persons. They are disproportionately single, and single elderly have much less income and much less assets than married couples. They are disproportionately 80 and older, and those folks have much less income and assets.

I think the notion that the middle class America is using up the Medicaid program by transferring all the assets away before Medicaid eligibility does not fit, at least with what I see, in terms of who is in nursing homes and who is in home care programs and how much of their own money they have spent before they get there.

Mr. **Gregg**. Well, that was not my notion. My notion is that if you set up a system which protects assets at whatever level CBO picks and the vast majority of people do not avoid exhausting their assets, then you will create a situation in which a large amount of the resources which are now privatized in the payment of long-term care will become unavailable and you will have to replace those private dollars with public dollars.

Mr. **Vladeck**. Unless you let people liquidate a part of their assets over time to pay a part of the costs of long-term care.

Mr. **Gregg**. Well, whatever part they liquidate, the vast majority of the people today, as you represent, are using up all their assets to get to Medicaid. At whatever level you set the threshold you are taking private money out and will have to replace it with public money.

Mr. **Vladeck**. That is correct. That is correct.

Mr. **Gregg**. And that could be a staggering number.

Mr. **Vladeck**. I do not believe so. I do not believe in terms of the proportion of folks using very large quantities of assets before they spend down to Medicaid is not—there was one simulation done either for the Senate Aging Committee or the House Aging Committee by some folks in Boston, at Harvard, last year or the year before. If I remember correctly, it shows that the average Massachusetts elderly household had sufficient assets to pay for something considerably under 6 months of nursing home care.

The amount of assets in the households that are at risk for long-term care in the aggregate are not that great. There are some number of households where they are great, but those folks never spend down.

If nursing home care as the most expensive piece of this costs $20,000 to $30,000 a year, then if your assets are $30,000, you spend down in 1 year. If we protect assets of $30,000 in the future, yes, those are replacing private dollars with public dollars.

But how much of that aggregate is compared to total long-term care expenditures, I am not sure it is an enormous amount.

Mr. **Gregg**. Well, I think you would want to get that figure before you made a decision.

Mr. **Vladeck**. Absolutely.

Mr. **Gregg**. Do you think there is any logic to splitting this process so that we have one system that addresses people who are over age 55 and another system that addresses people who are under age 55 or 50 or whatever figure you want? The approach assumes that people under a certain age have an earning capacity, that they should be able to anticipate the need for nursing home care and, thus, they should not receive the same benefits as people over a certain age.

Mr. VLADECK. Well, as I suggested in my testimony, at the time when we are substantially reducing public subsidy for higher education expense, at the time when we have no public subsidies for a variety of expenditure related to the welfare of younger children, to ask the working age population to take on another burden or else when you get to be 80 we are not going to protect you the way we have protected your parents—strikes me as unfair. I think we have enough problems with the average household in this country these days for those who have children—who, by the way, by having children are providing the best protection of the public purse against needing long-term care subsidy. But we are constraining them in so many other ways that to ask them to bear an additional burden at the time when their children are of college age or younger strikes me to be a lot to ask.

Mr. GREGG. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. In terms of cost effectiveness, likely resources, what should we do this year?

Mr. VLADECK. This year?

Mr. LEVIN. Yes.

Mr. VLADECK. I would do two things, assuming the level of budgetary constraint we have been working under. One is I would really try to get the HCFA based R&D effort and the other research efforts, and especially the demonstration component of that, geared back up. I would want to go ahead and do the urban swing bed demonstrations that were mandated twice before in the past and never got under way. I would like to take some of the demonstration waiver applications that were in the pipeline in 1981 or 1982 and try them now. I would like to put some relatively limited number of dollars in that.

I would also like to specifically target some research and demonstration activities on this extended care benefit, on the potential standards one would have, eligibility criteria one would have, benefit structures one would have, reimbursement mechanisms one ought to use, for those beneficiaries finishing acute stays. Some of them now are outpatient, some of them who have had cataract surgery, for example, or other kinds of outpatient surgery who could benefit very enormously from a 10- or 15-day extended care skilled confinement, and who thereafter might be less heavy users of home care or physician services or of hospital readmissions.

I think somebody has got to sit down and start pulling together what that benefit would look like in detail, and we could start doing that right now. And we could then cost it out, and perhaps next year decide that to begin implementing it would not even cost that extraordinary an amount of money.

Mr. LEVIN. And for those two efforts we are talking about how much more or less, would you guess?

Mr. VLADECK. I don't think you could use, I would guess, in excess of $20 or $30 million on an annualized basis. You could not spend it rationally. You do not have enough folks who would be in charge of administering the spending or doing the research or doing the studies or whatever to use it effectively.

Mr. **Levin**. Thank you.

Chairman **Stark**. Bruce, thank you very much.

Mr. **Vladeck**. A pleasure. Thank you.

Chairman **Stark**. We will now hear from a panel consisting of Mr. Josh Wiener, a senior fellow at the Brookings Institution; Jack Meyer, who is president of New Directions for Policy; and Mark Meiners, Senior Research Manager of the National Center for Health Services Research and Health Care Technology Assessment, U.S. Department of Health and Human Services.

Chairman **Stark**. Welcome to the committee, gentlemen. We have your prepared testimony. Without objection it will appear in the record in its entirety.

If you wish to expand on your statements, why do you not begin in the order that we have you on the witness list. Joshua Wiener.

## STATEMENT OF JOSHUA M. WIENER, PH.D., BROOKINGS INSTITUTION

Mr. **Wiener**. Thank you, Mr. Chairman. It is a pleasure to be here before the committee. Perhaps no other part of the health care system generates as much passionate dissatisfaction as does the organization and financing of long-term care for the elderly.

There are really two principal problems that have gained attention. One is the catastrophic costs that the elderly face and the other is the large public costs which are growing rapidly.

If these are the problems, what is to be done? In this recent report on catastrophic health care costs, Secretary of Health and Human Services Otis Bowen recommended relying solely on private sector approaches to solve these problems.

While expansion of private sector financing mechanisms is both desirable and likely, our research at the Brookings Institution suggests that they cannot be the total solution.

Even with some very generous assumptions about participation, our findings are that private sector mechanisms are unlikely to finance more than a modest proportion of total nursing home and home care expenditures and will have only a small impact on Medicaid expenditures and the number of people who spend down to Medicaid eligibility levels.

For example, taking private long-term care insurance, even with projected increases in income and assets over time, we project that in the year 2018 perhaps 25 to 45 percent of the elderly could afford long-term care insurance. Private insurance would account for between 7 and 11 percent of total nursing home expenditures and would reduce Medicaid expenditures and the number of people who spend down to Medicaid eligibility levels by 2 to 5 percent.

Why is the impact of private sector approaches so modest? I think there are basically two problems. On the one hand, these private sector financing mechanisms are simply too expensive for most people, even assuming substantial increases in real income and assets over time.

And the other problem is that long-term care products are currently flawed in a variety of ways that limit the degree of financial protection that they offer.

Again, turning to private insurance, some of these restrictions include preexisting condition exclusions, not selling to the disabled, prior hospitalization requirements, restrictions on the levels of care and indemnity benefits that are not indexed over time.

What I think has been happening within the policy community is that people have been looking at premiums at age 65 and while finding them significant, not overwhelming.

The problem is that one is unlikely to use the ~~benefit~~ at age 65. One uses it 20 years down the road at age 85. And at even a fairly modest inflation rates, a $50 per day indemnity benefit needs to be $150 20 years later. With very rare exceptions policies are not providing that level of indexation.

The problem is that at least so long as we are within the elderly population, improved coverage and affordability are trade-offs. That is, coverage improvements are likely to make products more expensive, thus, reducing affordability. For example, indexing the indemnity level would probably increase the premiums by about 50 percent.

So, I think the future of private sector approaches is that more people will participate. From an investment perspective of an insurance company, it is a potential multibillion dollar market and there is a lot to be done.

From a public policy perspective, though, the picture is not quite so rosy. There is relatively little impact on Medicaid expenditures or on the number of people who spend down to Medicaid.

The limitations on the private sector approaches, I think, leave two broad options. One is to more or less continue to muddle along with the current financing system we have now, making marginal improvements. I would certainly put on that list of marginal improvements raising the personal needs allowance, raising the level of protected assets, and protecting the community based spouse. There are a variety of things that we can make—do to make the current system less onerous.

Despite its many deficiencies, the fact is that the current dependence on the Medicaid program is not all bad. It is probably the least expensive public program possible and it does provide a safety net for all elderly.

But it does not do anything about catastrophic costs and it does not do anything to spread the costs over time. The working population in 2050 is going to have to pay a lot to cover these expenses out of current earnings.

The other alternative is some form of public insurance, most likely through an expanded Medicare program. In my view, only this public insurance option can meet the basic needs of the vast majority of elderly.

Moreover, while the costs are not trivial, they need not be overwhelming, especially if we build up financial reserves to pay for the baby boomers as we are doing with Social Security.

We have estimated that a 2.5 to 2.8 percent payroll tax, employer and employee combined, would pay for a very generous expansion of Medicare and nursing home and home care benefits and all Medicaid long-term care expenditures.

Less generous programs, which is the direction I think we should go, could be financed with lesser taxes.

In order to solve the problems of long-term care, we need a two-tier public/private mix. On the first tier, we need a public program that provides a degree of financial protection for everyone. On the second tier, private sector financing mechanisms, like pensions, should fill in the gaps and provide a higher level of financial protection for those who want it.

A combination of expanded public insurance program and supplemental private initiatives, I believe, provides the best hope of providing protection against catastrophic costs for all elderly and provides a rational way of raising the money needed to pay for those costs.

Thank you.

[The prepared statement follows:]

# FINANCING AND ORGANIZATIONAL OPTIONS FOR LONG-TERM CARE*

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*These opinions are those of the authors and should not be attributed to other staff members, officers, or Trustees of the Brookings Institution.

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## I. Introduction: Need for New Directions

Perhaps no other part of the health care system generates as much dissatisfaction as does the organization and financing of long term care (LTC) for the elderly. The disabled elderly and their families confront a fragmented delivery and financing system, a relative lack of noninstitutional services, long waiting lists for institutional placement, mediocre quality care, and financial hardship. Paradoxically, public financing, primarily through Medicaid, is perceived as overly expensive yet resulting in an inadequate system.

The long range demographics of the elderly will place increasing strain on this imperfect system. The aging of the baby boom population combined with falling mortality rates for the aged suggest a sharply increasing demand for long-term care which will require substantially greater public and private expenditures. Projections of current age/sex specific nursing home utilization rates suggest that there may be four times as many persons in nursing homes in 2040 as there were in 1980.

The projected large increase in the need for long-term care presents both a problem and an opportunity for reform. Fundamental policy questions must be addressed if we are to do better in the future than we are doing now. Is there a better way to organize the delivery system than merely making the current system a lot larger? Will "society" be willing to pay for the current system multiplied by three or four? Is there a better way to finance care?

## II. Options for Reform: Private Sector Approaches to LTC

Interest in private sector approaches to financing long-term care has grown substantially in the last few years. Why has this occurred? One reason is that the Reagan Revolution ideologically and the Reagan budget deficits practically have made large scale increases in public programs difficult, at least for the near term. This assessment of the public role has led many to look for other sources of financing.

Another reason for the interest in private sector approaches is that the financial position of the elderly has improved markedly in the last 15 years. For example, the poverty rate among the elderly fell by 50 percent from 28.5 percent in 1966 to 14.1 percent in 1983. Danzinger et al. found that after adjusting for the lower tax rates, availability of asset income, and living arrangements, the elderly on average have about 90 percent of the income of nonelderly. Hurd and Shoven found that between 1970 and 1980, the real incomes of the elderly increased faster than the income of the rest of the population. Most projections of income of the elderly show an improved income position.

Five of the most commonly mentioned private sector approaches are private long term care insurance, social/health maintenance organizations, continuing care retirement communities, home equity conversion, and individual medical retirement accounts for long-term care.

### A. Private LTC Insurance

Proponents of private long-term care insurance begin with the assumption that commercial insurance can be developed that will provide a reasonable amount of financial protection at premium levels that Americans can afford. Premiums would be collected from a large group of people and benefits provided to the relatively few who need care.

At present, at least 31 insurance policies provide some form of private long-term care insurance.

Advocates of private insurance argue that this approach has many advantages. First, it builds on the well-known willingness of the elderly to purchase Medigap insurance. Approximately two-thirds of all elderly own a Medigap policy and high levels of coverage persist even at relatively low income levels. Second, since it does not require the development of a major new service delivery structure, it can be expanded relatively quickly into a major financing source. Third, by spreading the risk of long-term care costs across a broad population, the burden placed on any one individual to finance the costs of catastrophic care would be reduced. Fourth, private insurance is a non-compulsory alternative which allows the individual to maximize utility, and provides him greater flexibility in meeting his needs.

Potential difficulties with private long-term care insurance include: First, there is the danger of adverse selection. That is, only people who need the insurance will buy it, driving up utilization and the price of the policies. Insurers typically try to protect themselves against this by screening for health conditions, prohibiting coverage for pre-existing conditions, excluding coverage of mental illnesses (treatment of Alzheimer's diseases under existing policies is unclear), requiring care to be in skilled nursing facilities, providing reimbursement only if there is a prior hospitalization, and marketing only to the well-to-do. The fact that policies have been marketed on an individual basis makes these screenings relatively easy to implement since the insurance broker typically deals directly with the purchaser. Unfortunately, to the extent that insurers succeed in screening out high-risk individuals, they may exclude the people who most need the coverage. While insurance companies have treated their utilization data as proprietary information, the limited information available suggests that current policies have some favorable selection.

A second problem is that insurance coverage will induce increased demand and utilization ("moral hazard"). One of the consequences of insurance is to lower the effective price of services. Conventional economic theory tells us that people buy more of a good or service when the price is lower. Increased demand could be a particular problem if the insurance covered home care, which is an attractive addition to the informal care provided by the family. Insurers try to protect themselves against moral hazard by using high deductibles and by limiting coverage to nursing home care. Unfortunately, high deductibles limit the degree of financial protection this proposed reform would offer and the exclusion of home care may exacerbate the already strong institutional bias that exists in the current financing system.

A third potential problem is that there is uncertain market interest in private long-term care policies. First, most elderly and virtually all nonelderly substantially underestimate their chance of long-term disability. In addition, there is a widespread misunderstanding of what Medicare covers and the availability of Medicaid. In a survey of its membership, AARP found that among respondents who believed that they would at some point have an extended stay in a nursing home, nearly four-fifths believed that Medicare would pay for all or part of their stay. This is manifestly untrue; Medicare accounts for only about two percent of nursing home revenues and the average length of covered stay is only 30 days. Yet many discover this only when they need care. Moreover, many in the insurance industry believe that the elderly will not buy long-term care insurance because of the availability of and willingness to use Medicaid as a "safety net" to pay for nursing home care.

Fourth, it is widely believed that third party payment for acute care has been partially responsible for rapidly rising hospital and physician costs. It is possible that long-term care insurance may have a similar inflationary effect.

Finally, premiums are high, thus limiting the market. For example, the Fireman's Fund long-term care policy costs $608 a year for those aged 67 and rises to $1710 for those aged 80. Long-term care insurance represents a substantial increase in out-of-pocket health care expenditures for most elderly and a virtual doubling or more of their Medigap premiums. Reducing costs by spreading the risk over the working population seems unlikely since many companies are reducing their health benefits and may be unwilling to make long-term care insurance a fringe benefit.

B. Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) are financially self-sufficient settings for the elderly that combine residential units with the availability of medical, nursing and social services in specialized facilities on the premises. The underlying concept is one of pooled risk to provide a lifetime continuum of care. These communities typically require a large up-front payment of $60,000-100,000 and then monthly fees of $1,000 or more. Although the industry has historically been dominated by nonprofit providers, the for-profit sector (e.g., Beverly Enterprises, Marriott Corporation) is becoming increasingly involved.

Proponents of CCRCs note that these organizations combine an organized system of care with financial incentives for cost effectiveness in an insurance-like setting of pooled risk. Using an insurance-like mechanism of pooled risk, the burden on the individual of paying for his care is reduced. She "knows" that she will receive the care she needs. In addition, by having a relatively large number of elderly in one place, CCRCs may be able to provide in-home services less expensively and forestall or prevent the need for more intensive services. CCRCs have a strong financial incentive to provide care in a cost-effective manner.

Proponents also note that quality of life may be enhanced with CCRCs. Noninstitutional services are more available in CCRCs. In addition, the communal living environment and focus on independence could have a positive effect on the elderly. A support system of peers might help buffer the stresses of aging. Moreover, when an elderly resident needs to be institutionalized, the usual stresses associated with relocation may be minimized because she is only moving to another part of the community.

On the other hand, there are many obstacles to CCRCs. First, CCRCs are expensive, thus restricting the potential market. Second, not only do CCRCs select higher income people, but they mostly restrict entry to only the healthy elderly, thus excluding those most in need of long-term care services. Third, in some relatively rare but highly publicized cases, CCRCs have been financially unsound and have gone bankrupt. Residents who have spent their life savings to join these CCRCs have been left stranded. As CCRCs become increasingly attractive to real estate speculators, this could become a more frequent occurrence. Fourth, with increasing frequency, CCRCs have been charging additional fees for intensive services, and therefore do not fully protect against catastrophic expenses faced by some elderly. Finally, CCRCs necessitate that people move out of their homes and into another setting. Most elderly do not want to give up their homes or live in a highly organized setting.

### C. Home Equity Conversion

Home equity conversion is built on the observation that the most important asset of most elderly (i.e., their homes) is not at all liquid. As a result, the elderly "live too poor and die too rich." This approach changes assets invested in home ownership into a stream of income which could be used to meet long-term care (or other) needs. In essence, the bank gives the homeowner a loan which is paid to the homeowner in monthly installments. At some time in the future, preferably after her death, the homeowner repays the loan with interest using the proceeds from the sale of the home.

Advocates of home equity conversion note that this is a relatively painless method to increase the income of the elderly and to provide funds for them to purchase long-term care insurance or services. Home ownership is extremely widespread. About 70 percent of all elderly households own their own home, including about 65 percent of low-income aged households. Thus, this is one private sector option that could include a substantial number of low-income individuals. Moreover, the amount of money that could be generated is significant. Jacobs and Weissert estimated that about one-third of all elderly could generate over $2,000 per year by converting their home equity to cash. Finally, home equity conversion appears to be especially financially attractive for single individuals at very old ages -- precisely the group which faces the greatest risk of entering a nursing home.

Although technically very promising, there are several potential problems with this approach. First, the elderly are generally unwilling to "let go" of their home asset. A large research literature suggests that the elderly do not use up their assets at anywhere near the rates predicted by the "life cycle hypothesis". In addition, since the home is already largely a protected asset under Medicaid, a policy that uses up the principal asset of the elderly in order to prevent Medicaid from using less important assets would seem to be perverse.

From the perspective of the financial institutions, there are also significant problems to overcome. Lending institutions have been very reluctant to enter into nontraditional relationships with the elderly under circumstances where the elderly might outlive their actuarial expectancy, which would force the financial institution to either foreclose or to postpone claiming the asset. Banks do not like waiting to be repaid and foreclosing on elderly widows conjures up the worst possible image of bankers. Neither option is very attractive to the financial community. The evolving consensus is that there is a need for some public mortgage insurance, a proposal which has scared away the Reagan Adminstration.

Finally, home equity conversion is an option which places the financial burden of long-term care costs on the individual and does not attempt to spread the risks across a larger population. Although it may generate enough income to purchase insurance (if it were more widely available and a better product), the income from the home equity conversion would not be enough to cover catastrophic long-term care costs.

### D. Individual Medical Accounts (IMAs) for Long Term Care

The idea of individual medical accounts for long-term care builds on the popularity of more general individual retirement accounts by expanding the concept to long-term care. This option would encourage individuals to save for their own long-term care by deferring the taxes on money placed into those accounts. After age 65, these funds would become available to purchase medical and social long-term care services.

Advocates of this approach argue: First, the private savings generated from IMAs could reduce the financial risk individuals face. This may enable individuals to prevent pauperization as a result of catastrophic nursing home costs. Second, individuals would have the flexibility to purchase the "best" service package most appropriate for their own long-term care needs. Relatedly, since service or insurance payments would be out-of-pocket, IMAs for long-term care would also provide incentives to reduce unnecessary service use and to seek cost-effective alternatives. Finally, IMAs could stimulate the long-term care industry to develop a wider range and better quality of long-term care services for the elderly. Since funds could be used for any service, the institutional bias of some other options could be avoided.

Again, there are obstacles to this approach. First, it is not clear that people are willing to save for such a single purpose, especially starting at early ages where enough assets could be accumulated so that the IMA might be useful. Few people expect to have an extended period of disability during their old age. In addition, most people have very little knowledge of long-term care and assume that Medicare or Medigap insurance will pay for it. Second, even at fairly substantial incomes, only a minority of taxpayers currently claim IRA deductions. For example, even at incomes between $30-40,000, only 27 percent of tax paying households claimed IMA deductions in tax year 1982. Presumably, most people would be more likely to use a general purpose IMA than a substantially restricted one. Third, compared to many other societies, the United States has a rather low savings rate. Over the years, a variety of efforts to increase the savings rate have failed. Most economists seem to think that IMAs did not increase the savings rate much if at all. Taxpayers merely moved money into tax deductible accounts at a substantial loss to the Treasury. At a time of substantial federal deficits, additional revenue losses should be avoided. Finally, tax incentives are inevitably an inefficient way to achieve social goals since they subsidize a certain number of people who were already going to do what the tax incentives sought to have them do.

### E. Social/Health Maintenance Organizations (S/HMO)

This approach extends the HMO concept of prepaid, capitated financing to include a variety of long-term care services. The principal premises are that a case-managed continuum of care will be cost-effective and that there can be enough savings on the acute care side (along with modestly increase premiums) to help finance expanded long-term care services. This approach is especially interesting because it consciously links the acute and long term care sectors, taking from acute care to give to long term care. Despite strong opposition from the Executive Office of Management and Budget, Congress included a provision in the Deficit Reduction Act of 1984 directing the Department of Health and Human Services to grant waivers for a four site demonstration of this concept.

Potential problems with this approach include: First, under conditions of excess demand, any expansion in noninstitutional benefits may result in increased costs because there cannot be any "real" savings in institututional utilization. Any nursing home bed emptied by diverting people from nursing homes may be filled by someone else waiting in the queue.

Second, an empirical question to be answered by the demonstration is whether there can be enough cost-effective substitution of long-term care for acute care, and noninstitutional services for institutional services to make S/HMOs work. As the demonstrations are ongoing, there has not been, as yet, any systematic studies of S/HMO utilization, costs, quality of care, enrollee satisfaction or marketing success.

Third, the comparative advantage of HMOs has always been that they had lower acute care expenditures. To the extent that Medicare hospital prospective payment reduces length of stay, that comparative advantage in acute care expenditures may decline somewhat, giving the S/HMOs less flexibility to design their service package. And, finally, although this is changing, the elderly have generally been reluctant to join HMOs. This is especially true of those with chronic illnesses.

### F. Will Private Sector Approaches Work?

The answer to this question depends on the criteria chosen. In order to systematically and consistently estimate the impact of various financing proposals on public and private expenditures, we developed the Brookings/ICF Long-Term Care Financing Model. We have used this model to answer four questions:

1. What proportion of of the elderly population could afford various private sector financing mechanisms?

2. What proportion of total nursing home expenditures could private sector expenditures finance?

3. What impact could private sector financing mechanisms have on Medicaid expenditures?

4. What impact could private sector financing mechanisms have on the number of people who spend-down to Medicaid eligbility levels?

In doing these simulations, we deliberately made generous assumptions about the willingness of the elderly to participate in these financing mechanisms. Thus, these estimates must be considered upper bounds of the possible impact of these mechanisms.

Our simulation results suggest that, with the exception of home equity conversions, only a minority of the elderly could afford private sector financing mechanisms. Moreover, private sector approaches are very unlikely to finance more than a modest proportion of total nursing home and home care expenditures and will have only a very small impact on Medicaid expenditures and the number of people who impoverish themselves down to Medicaid financial eligibility levels. For example, by the year 2018, long-term care insurance may account for at most 12 percent of total nursing home expenditures and may reduce Medicaid expenditures and the number of Medicaid nursing home patients by at most 5 percent.

Why don't private sector mechanisms have a bigger impact? Private sector options have a limited impact because they are too expensive to be affordable by most elderly and are flawed by limits that reduce the amount of financial protection that they offer. For example, most private long-term care insurance has prior hospitalization requirements, pre-existing condition exclusions, age limitations on who may purchase policies and reimbursement levels that do not increase with inflation. The difficulty is that improved insurance coverage and affordability are tradeoffs. That is, coverage improvements are likely to make products more expensive, thus reducing the number of people who can afford them.

On the one hand, there is clearly a very great potential for growth in the private sector. A potentially multibillion dollar market is still almost entirely untapped. From an investment perspective, there is nothing but good news in these simulations.

From a public policy perspective, the key question is whether private sector approaches can reach far enough down the income distribution to include those people who would otherwise spend-down to Medicaid and, therefore, materially affect public expenditures. These simulation results suggest that while small savings are possible, the savings do not change the basic long-range story of dramatically increased demand for publicly funded services in the future.

## III. Options for Reform: Public Sector Approaches

If private sector approaches are not a panacea, what are the prospects for the public sector? The increased demand for long-term care will mean inevitable increases in public expenditures. Since the number of working persons relative to the number of elderly will decline, there will be increased financial pressure.

It is easy, however, to work oneself up into an undue level of hysteria. This pressure will be mitigated somewhat by a growing economy. Moreover, even with a substantial increase, long-term care will not be a major part of gross national product (GNP). Long-term care is currently only about one percent of GNP and, even if long-term care expenses are multiplied by four, it should not be an extraordinarily large expenditure.

What, then, are some of the public sector options? The public sector options for reform fall into three categories. Some options, such as the Medicaid cap and block grants, seek to limit federal financial responsibility while giving more flexibility to the states. Other options, such as most proposals to make modifications in the current system and tax credits for care of the elderly, attempt to expand formal and informal noninstitutional services. Finally, other options seek to elaborate on insurance concepts by adding long-term care to Medicare and to health maintenance organizations.

### A. Medicaid Cap

On several occasions, the Reagan Administration has proposed capping federal Medicaid expenditures and allowing them to increase only at the medical care price index. States would be given increased flexibility to allow them to keep expenditures within the cap.

Proponents of this approach essentially argue that at a time of $180 billion deficits the federal government can no longer afford Medicaid as an open-ended entitlement program. Moreover, the current open-ended financing system encourages States to be inefficient and to allow expenditures to increase too quickly. The discipline of a "cap" combined with the increased flexibility would allow states to run their programs more efficiently.

Opponents argue that a Medicaid cap is not reform, but merely a way for the federal government to shift the problem to the states. Since there is no adjustment for demographic changes, there could be serious problems in the long run. Moreover, almost all of the new "flexibilities" that the Administration proposes are simply ways to cut people off the rolls, to eliminate services or to be as arbitrary in reimbursement as they propose to be with Medicare. In addition, transfer programs are best financed at the federal level, which has the greatest access to the fullest range of income sources. Income redistribution within Mississippi, for example, is of limited utility because Mississippi is so poor. Finally, recent work by Holahan analyzing the effects of the Omnibus Budget Reconciliation Act of 1981 (OBRA) suggests that children and AFDC adults are likely to bear the brunt of the cutbacks, groups already hard hit by earlier budget cuts. More broadly, it is grossly unfair to balance the budget at the expense of the lower-income population.

### B. Modifications of Existing Programs

This option covers a wide range of proposals, but most are geared towards increasing funding for noninstitutional services. These options include, but are not limited to: increasing funding for the Social Services Block Grant, easing the restrictions on Medicare home health and skilled nursing facility benefits, liberalizing the Medicaid home and community based service ("Section 2176") waiver program, and varying the Medicaid matching rates to provide incentives for the provision of noninstitutional services.

Proponents argue that the current system is too biased towards institutional services. There are a large number of people "in need" of noninstitutional services. In addition, the pressures of the Medicare hospital prospective payment system to reduce lengths of stay cannot be adequately accomodated within the existing Medicare/Medicaid long-term care system. Many patients need services that are not covered. The result is that some patients are inappropriately discharged from the hospital into a setting where they do not receive adequate care.

On the other hand, while many of the proposals may have merit, they would increase rather than decrease public expenditures. There is no shortage of worthwhile ways to spend more money. Shouldn't public programs for the poor receive the bulk of any increased public spending? In addition, if we are going to have trouble sustaining the existing level of services in the future, should we really be expanding them now? Finally, all of these options are subject to the criticism that they merely tinker with the current highly defective system and more radical change is needed.

### C. Public Long Term Care Insurance

This approach would create a Medicare-like insurance program for long-term care as Title XXI or Part C of Medicare. Most plans would be financed through a combination of tax dollars and premiums. The universal entitlement approach has the clear advantage of avoiding many of the technical problems of private insurance, principally adverse selection. Spreading the cost over the entire population is bound to reduce the financial burden on any one individual. Moreover, in theory, it offers the opportunity to develop substantial financial reserves that can be used latter when the "baby boom" population needs long-term care, a strategy being used very successfully in Social Security.

On the other hand, the program is bound to be expensive because of the large potential demand, the entitlement mentality, and pressures to have tax revenues rather than premiums pay for an ever increasing portion of the costs (as has happened with Medicare Part B).

## IV. Conclusions and Recommendations

In his recent report on catastrophic healthc are costs, Secretary of Health and Human Services Otis Bowen recommended relying soley on private sector approaches to solve the problems of catastrophic health care costs and rising public expenditures. While expansion of private sector financing mechansisms is desirable and likely, our research suggests that they cannot be the total solution.

The proposals by Secretary Bowen to improve the protection against catastrophic health care costs by expanding Medicare coverage are a step in the right direction. However, limiting that protection to hospital and physician costs leaves the gapping hole of nursing home and home care expenditures that even a vastly expanded private sector cannot fill by itself. A combination of an expanded public insurance program and supplemental private initiatives provides the best hope of providing protection against catastrophic costs for all elderly and provides a rational way of raising the money needed to pay for these costs.

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## Chart 1

## KEY ASSUMPTIONS IN MODELING THE OPTIONS

Long-Term Care Insurance ($30, $40, and $50 Per Diem): All nondisbled individuals and couples at age 67 with $10,000 in assets who can afford the insurance premiums with 5 percent or less of their income purchase policies. The policy provides 6 years of nursing home care after a 100 day elimination period at a rate of $30, $40, or $50 per day (in 1986 dollars) depending on what the individual can afford. The indemnity level is moderately indexed for 10 years after initial purchase. A prior hospitalization requirement allows 75 percent of persons who meet the elimination period to receive benefits.

LTC Insurance ($50 Per Diem Benefit): This is the same insurance policy as above except that individuals only purchase policies if they can afford the $50 nursing home per diem indemnity level.

LTC Insurance (2 Year) For All With Pension Benefits of $500+: Individuals (not couples) receiving pension benefits of $500 per year or more are assumed to receive a 2-year LTC insurance policy which has a 90 day elimination period and pays $50 per diem (in 1986 dollars) for nursing home care. One-half of the cost of the insurance is deducted from each person's annual pension.

Individual Medical Accounts: Individuals may contribute up to $1,000 a year to an individual medical account (IMA) to be used exclusively for long-term care. Only those persons at the individual retirement account (IRA) maximum contribute to individual medical accounts. Ninety percent of individuals at the IRA maximum contribute to IMAs.

Social/Health Maintenance Organizations: This S/HMO is modeled on the SCAN demonstration site in Long Beach, California. The plan covers $7,500 (in 1986 dollars) of long-term care services annually. Policies are purchased if the cost is less than 5 percent of household income. Disabled individuals may purchase policies. Reflecting the organizational development and enrollment barriers, only 50 percent of the elderly who can afford S/HMOs actually purchase policies.

Continuing Care Retirement Communities: CCRCs are modeled as comprehensive long-term care insurance policies. Individuals and couples are assumed to join CCRCs if they have 130 percent of the income necessary for the monthly payment and if they have enough total assets to pay the entrance fee and have $10,000 in assets left over. Half of disabled individuals join CCRCs if they have enough income and assets. Given the reluctance of the elderly to move, only 50 percent of qualifying individuals and couples join CCRCs. Individuals join CCRCs at age 76.

Home Equity Conversions: All individuals and married couples with $25,000 or more in home equity take out a home equity loan at age 75. Repayment of the loan is postponed until after death and all appreciation on the home accrues to the mortgage company.

Table 1

Percent of Elderly With Private Sector Options: 2016-2020

| | Percent With Option |
|---|---|
| LTC Insurance ($30, $40, or $50 Per Diem)[a] | 45.0% |
| LTC Insurance ($50 Per Diem)[a] | 26.3% |
| LTC Insurance (2 Year Policy) for All with Pension Benefit of $500+ | 41.3% |
| Individual Medical Accounts | 18.2% |
| Social/Health Maintenance Organizations[b] | 26.3% |
| Continuing Care Retirement Communities[c] | 7.1% |
| Home Equity Conversion[d] | 63.3% |

[a] Ages 67+.

[b] 1/2 of those who can afford to join.

[c] Individuals and couples join CCRCs at age 76. Percentage is for all elderly 76+.

[d] Percentage of individuals and couples at age 75 who have $25,000 (in 1986 dollars) in home equity.

Source: Brookings/ICF Long-Term Care Financing Model.

## Table 2

## Level and Percent of Nursing Home Expenditures Financed by Private Sector Options: 2016-2020[a]

| | Nursing Home Expenditures[b] |
|---|---|
| Base Case | $98.1 (100.0%) |
| LTC Insurance ($30, $40, $50 Per Diem) | $11.7 (11.3%) |
| LTC Insurance ($50 Per Diem) | $ 7.0 ( 7.1%) |
| LTC Insurance (2 Year Policy) for All with Pension Benefit of $500+ | $14.8 (14.7%) |
| Individual Medical Accounts | $ 2.9 (3.0%) |
| Social/Health Maintenance Organizations | $10.0 (10.3%) |
| Continuing Care Retirement Communities | $13.5 (13.7%) |

[a] Estimates in billions of 1987 dollars.

[b] All percentages are of total nursing home expenditures for that option. For example, for Long-Term Care Insurance ($30, $40, and $50), private insurance accounts for 11.3 percent of total nursing home expenditures and Medicaid, Medicare, and out-of-pocket payments account for 88.3 percent of total nursing home expenditures. Since each option is separate, the column cannot be summed.

Source: Brookings/ICF Long-Term Care Financing Model.

Table 3

Level and Percent Change from Base Case of Medicaid Nursing Home Expenditures for Private Sector Options: 2016-2020[a]

| | Medicaid Expenditures[b] |
|---|---|
| Base Case | $46.2 |
| LTC Insurance ($30, $40 and $50 Per Diem) | $43.9 (-5.0%) |
| LTC Insurance ($50 Per Diem) | $45.5 (-1.5%) |
| LTC Insurance (2 Year Policy) for All With Pension Benefit of $500+ | $40.5 (-12.3%) |
| Individual Medical Accounts | $45.6 (-1.3%) |
| Social/Health Maintenance Organizations | $42.6 (-7.8%) |
| Continuing Care Retirement Communities | $45.0 (-2.6%) |
| Home Equity Conversions | $47.1 (+2.0%) |

[a] Estimates in billions of 1987 dollars.

[b] All percentages represent changes in Medicaid expenditures from the base case. For example, for LTC Insurance ($30, $40, $50), Medicaid expenditures are 5.0 percent less than under the base case ($43.9 vs. $46.2 billion). Since each option is separate, the column cannot be summed.

Source: Brookings/ICF Long-Term Care Financing Model.

## Table 4

### Number and Percent Change from Base Case of Medicaid Nursing Home Patients for Private Sector Options: 2016-2020

| | Medicaid Patients[a,b] (Millions) |
|---|---|
| Base Case | 2.34 (-) |
| LTC Insurance ($30, $40, and $50 Per Diem) | 2.24 (-4.3%) |
| LTC Insurance ($35 Per Diem) | 2.30 (-1.7%) |
| LTC Insurance (2 Year Policy) for All with Pension Benefit of $500+ | 2.19 (-8.5%) |
| Individual Medical Accounts | 2.30 (-1.7%) |
| Social/Health Maintenance Organizations | 2.21 (-5.6%) |
| Continuing Care Retirement Communities | 2.28 (-2.6%) |
| Home Equity Conversions | 2.40 (+2.6%) |

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[a] Ever in a nursing home during the course of a year.

[b] Represents percentage change under the option from the base case. For example, for LTC Insurance ($30, $40, and $50), there are 4.5 percent fewer Medicaid patients than under the base case (2.24 vs. 2.30 million). Since each option is separate, the column cannot be summed.

Source: Brookings/ICF Long-Term Care Financing Model.

Chairman **Stark**. Let us take another minute and ask you how you divide between Government financed and private insurance.

Mr. **Wiener**. I think any public program that you would want would have significant deductibles and coinsurance. At the first level, the private sector would offer some sort of medigap type products.

But I think you could also develop financing and delivery systems, like social HMOs, continuing care retirement communities, a variety of those approaches that could be used to provide a better set of services than the public program could provide.

Chairman **Stark**. Jack Meyer.

## STATEMENT OF JACK A. MEYER, PH.D., PRESIDENT, NEW DIRECTIONS FOR POLICY

Mr. **Meyer**. Thank you, Mr. Chairman. I would like to start by summarizing my statement, which I submitted in full, through ticking off six of the key problems with the long-term care system.

I think if we plunge into trying to add more money to this system without dealing with these problems, we stand a substantial chance of wasting a lot of it.

The first problem with public programs is the institutional bias, receiving public money is tied to being in an institution.

The second problem is a bias toward front-end coverage, particularly under Medicare. What we cover is the first 100 days in the SNF and so on.

Little in the way of back end protection is related to the third problem, namely, that government help is only provided through a Medicaid safety net that has a big sign on it that says "paupers only." You have to go through a free fall, as you well know, to get into that door.

And our public effort has tarnished with the welfare image that does not well suit a long-term care program.

A fourth problem is very important. That is a fragmented payment system, with little coordination of long-term care and acute care. I think there are savings here from coordinating these elements, as Josh has alluded to and others have mentioned, that could finance internally a portion of the extension of long-term care benefits.

A fifth problem is too much economic regulation with too little emphasis on quality.

And, finally, No. 6, too little information or clearinghouses of information for senior citizens to know what social services are available and how they can be coordinated.

An additional problem is that the private sector mirrors rather than complements public programs. It has the same biases, the same types of restrictions, so that you do not get the nice mesh or fit that you would like.

But I feel the private sector has great potential, both in financial and human terms.

Financially, we know that about $700 billion is under the ground in the equity of the homes of elderly people. It will not be easy to tap that, but I am intrigued with some recent experiments that are finding ways to eliminate the possibility of senior citizens being evicted from their homes if they do take a reverse mortgage. That is an understandable fear.

I think that we cannot just look out there now in the private sector and say, "That is all there is and it has these restrictions."

We can say, "How could we refine it and develop it," and I am going to comment in a moment about how private sector initiatives might be enlivened if we had a better set of public sector programs.

But the potential is there. And I think there's a human potential in millions of volunteers, and I say this recognizing the tremendous commitment that spouses and children are making now.

But I think there are also a lot of healthy young elderly who could help if they were mobilized in areas of personal needs—bathing, trips to the doctor, being turned in bed—these kinds of things that are probably not going to be solved by a government program alone.

It requires leadership and education, but I think that a private sector strategy also requires a more rational government strategy. I think the two go hand in hand.

I would not rely on Medicaid for a major effort in this area, but I do think we should clean it up and make it available to more of those who are poor.

I would start there by not impoverishing the spouse of a nursing home resident as much as we do now, by paying a decent personal needs allowance and by having Medicaid pay some of the front-end costs, the so-called buy-in costs—co-payments and deductibles—for those people who have very low incomes.

In addition to these steps, and I provide some cost estimates of these in my testimony, I think we have to understand the importance of the SSI program to health care. SSI is the gateway to Medicaid for senior citizens, just as AFDC is for younger people.

And I would start in the SSI program by relaxing the asset test, which is very restrictive today, to allow more low-income citizens to have access to Medicaid and to increase benefits in stages, particularly for individuals who now receive a maximum under SSI of only three-fourths of the poverty line.

I think we also need efforts for increased participation among those who are eligible. I have a new study that was released yesterday that I have coauthored with Sheila Zedlewski that costs out all these provisions in detail and shows how they could be financed and how many people would be lifted out of poverty.

One finding from our study is that if you raise SSI benefits in stages to the poverty line, an estimated one and a half million senior citizens and disabled individuals would be lifted out of poverty.

And that is a significant figure. In that same study, we also suggest various ways to pay for this improvement in benefits.

The important point here is not to talk about SSI in its own right, but rather to note that it is a gateway to Medicaid and millions of elderly people who are poor are not in the SSI program, and therefore they are not in Medicaid.

With regard to Medicare, I think the Government needs to totally overhaul this program. Right now it is like a roulette wheel. If what you land on is one of the covered services, you may end up only paying the TV bill or the phone bill.

But if what you land on is in the long-term care area, you may be exposed to some $50,000 or more in unlimited, uncompensated, unreimbursed expenses.

That is not the way to run an insurance program, I am sort of amused at the battle over the back end of part A, with both the public and private sectors clamoring to get the business and with the private sector accusing the public sector of taking the business away from them.

It is quite a different dialogue when you move out of the back end of part A, to long-term care where you clear the room when you bring up that subject, as Bruce Vladik noted. Of course, we do need to protect senior citizens in the acute care area as well. But that is easier to do.

I would recommend implementing a full protection provision across the board in a service-neutral way under Medicare at the back end, not tied to SNFs, not even tied to a nursing home, but a kind of stop loss provision related to expenditures, a stop-loss would be one way to do it; another way involves a reinsurance role for the Federal Government where the Federal Government would reinsure private sector policies for those unusually large expenses.

It is done in other areas. Something like this concept of reinsurance is part of an experiment under the Medicaid program in Santa Barbara, Calif.

Obviously, to keep this from breaking the Federal bank, which is already going to have difficulty funding Medicare, we would need a waiting period, a definition of functional disability and substantial coinsurance, with Medicaid paying the coinsurance for low-income senior citizens.

Let me just say a word on how to pay for this. In my testimony I have listed several ways to pay for some expansion of Medicare at the back end.

One step involves taxing more of Social Security benefits. One option here is to tax 85 percent of benefits above thresholds of $16,000 and $12,500 for couples and singles respectively. We estimated the revenue gain of that option at $5.5 billion for 1988.

Taxing the portion of the actuarial valve of Medicare benefits that is not contributed by the beneficiary, as I think the bill you cosponsor with Congressman Gradison envisions, Mr. Chairman, is another option. Increased revenue from the estate tax or taxing capital gains at death are also options, along with, cutting Government expenditures in areas not related to human needs. Finally, there is the possibility of raising the payroll tax base, which is regressive and could be raised somewhat from its current level of $43,800; and, frankly, we could pay at least a small part of the bill through savings from running a more efficient long-term care system.

I think if these kinds of steps are combined with mobilizing voluntary networks, they will breathe life into the private insurance market.

If the insurers, the HMOs and others know that there is some catch at the back end after a time period such as 2 years or after a certain amount, such as $100,000 is spent, then I think they will be more likely to move into this market.

Thank you.

[The prepared statement follows:]

## STATEMENT OF JACK A. MEYER, PRESIDENT, NEW DIRECTIONS FOR POLICY

Mr. Chairman: Thank you for the opportunity to testify before this committee on the important subject of long-term care for the elderly. My testimony will be divided into three sections--1) outlining the key problems we face in this area; 2) recommending strategies for addressing these problems; and 3) suggesting alternative ways to finance additional spending that is part, but not all of the requisite solution.

### I. The Basic Flaws in Our Current System

I will begin by listing some of the fundamental flaws in our current system of financing and delivering long-term care:

Insurance coverage is quite limited

* Health insurance often stops at the hospital door; Medicare provides limited coverage for post-acute care in an institutional setting (e.g., 100 days in a SNF-bed with a high copayment after the 20th day). Medicaid only kicks in after virtual total asset depletion, and then coverage is only for care in a nursing home.

* Thus, insurance coverage is tied to institutional care and forces many people into a difficult choice--moving into an institution versus little or no care at all; the help is not only all-or-nothing in this sense, but also in the sense of "all" if you are pauperized and "nothing" if you still have a red cent left to your name.

* Coverage for home care under Medicare and Medicaid is quite limited and is tied to expenditures ordered by physicians for those on a clear path to recovery. Coverage is more oriented to equipment than to custodial needs.

* The bitter irony here is that despite roughly $120 billion dollars per year in federal and state outlays for Medicare and Medicaid, they are often not there when you really need them. These programs have always reflected a bias toward front-end coverage, with back-end exposure to unusually-high outlays; this is just the opposite of what insurance is supposed to do. And, the programs have always reflected a bias against care outside the institution. Finally, they originally also reflected a poorly-conceived cost-based reimbursement system. Here, at least, the federal government can point with pride to some real progress in recent years although there are battles left to fight as anyone who examines the way Medicare pays doctors realizes.

* Lest I seem to be picking on the government, let me hasten to add that government only mimicked the system it found in the private sector when it established Medicare and Medicaid. In fact, tranporting that system, lock, stock, and barrel, from the world of private insurance into the new public programs was a part of the deal that brought them to life.

* Private insurance for long-term care is also quite limited; generally speaking, it rounds out and fills in what Medicare covers, but does not really complement Medicare and Medicaid in any meaningful sense. Private coverage mirrors public programs in many ways, adopting many of the same coverage restrictions found in the public sector. There is very little private coverage for home care, particularly of a custodial nature.

* Both public and private health coverage, then, are tied to the standard medical model and to health care in an institutional setting. Yet, we know that increasingly the need is occurring outside of institutional settings and outside the traditional medical model. Of course, we need standard medicine and basic research, but we also need much more emphasis on gerontology, social services, and support for families providing long-term care to a relative.

## The Payment System in Health Care is Fragmented.

* Insurers operate in the DRG world—or its private sector counterparts that are fast emerging—for hospital costs, a different system for paying doctors (even for work done in the hospital), another system for immediate post-acute or transitional care, and other systems still for nursing homes and longer-term home care.

* Providers survive financially in this world not by getting the patient fully recovered, but by moving him or her on to the next fragmented part of the system. The name of the game is to get them through the gate. For example, there is nothing in the financial structure of the Medicare payment system that makes it financially attractive for an insurer to keep a patient in a hospital a couple of days longer where that might avert a lot more costs after the patient leaves or even avoid a readmission.

## The federal tax system does not adequately encourage families to provide either transitional or long-term care

* There is no tax credit for elder-care that would be analogous to the child care credit; yet, elder care responsibilities can inhibit work just as can child care responsibilities

* Current law provides a deduction to a household that is responsible for half or more of the expenses of a person who is then deemed dependent. This creates a notch problem, with no incentive to help fund care that will amount to less than half of total expenses.

## Medicare coverage is confusing, many people still believe they are covered for more long-term care than they are, and it is difficult to go to one source of information about available health and related social services.

* Hospital discharge planning records often do not permit tracking the patient after hospitalization;

* It is difficult to find one place in a community where a person can go to get a picture of the array of available services. There is a need for clearinghouses and more coordination of one service with another.

## Facilities and Services for Long-Term Care Are in Short Supply in Some Areas

* Health planning agencies and states have put lids on the delivery system, in an effort to control costs by controlling supply. Freezing market entry not only leads to shortages and waiting lists, but also thwarts innovation. Certificate of need programs (C-O-N) became a "capital protection" device that insulated those already in the system from those on the outside seeking entry. This process underwrites inefficiency in health service delivery.

* Obsolete licensure requirements, or those sought by one group of professionals to limit competition from another, can also hold down the supply of services. The "over-professionalization" of services that results from overly-restrictive licensure requirements is a particular problem for long-term care because so much of it does not require highly-professionalized personnel.

* Assuring quality does not necessarily require that everyone who helps the elderly have a Masters degree. For many tasks, continuity of care, vigilance, and caring itself may be more important than the precise training of the care-giver. This is not to deny that other tasks do require formal or technical training. However, tasks such as IV transfusion, help with bathing, turning a patient in bed, etc. are increasingly important. And, many patients need to be taken to the doctor while others need companionship or someone to check in with them regularly. Our system is not well geared to meeting these needs. And, the solution does not lie with a simple expansion of government programs into these

areas. I do not think government should move in with front-end funding for every social/medical service.

## While There is Too Much Economic Regulation, There is Too Little Quality Assurance Monitoring

* As an accompaniment to relaxing strictures against market entry, we need to develop clear standards for the quality of transitional and long-term care that occurs in hospitals (e.g., swing beds), nursing homes, board and care facilities, and other settings. In other words, instead of freezing the market, we should thaw it out and guard against abuse through a combination of public and private performance standards (instead of rigid, inflexible design standards).

* Some caregivers are very poorly paid, discouraging their participation and jeopardizing quality of care.

## Many Elderly People Lack the Resources to Pay for Uninsured Long-Term Care on an Out-of-Pocket Basis

* Even a few weeks of visiting nurses, therapists, or paid companionship can amount to a sizable amount of money. Medicaid does not help until resources are almost totally dried up. And, many of these home care services, as noted earlier, are not covered by private insurance.

* Out-of-pocket expenditures for health care accounted for 20 percent or more of annual income for an estimated 4.3 percent of all Americans, according to one estimate (Berki, *Health Affairs*, Winter 1986). But, among those with incomes below $12,000 a year, the corresponding figure was 8.7 percent, or twice as high. Indeed, according to the figures presented by Berki, based on the NEMCES Survey, 18.4 percent of those with incomes equal to or below the federal poverty threshold spent 20 percent or more of their incomes on out-of-pocket medical expenses. This is a stark reminder that catastrophic level medical expenses might be as "low" as $3,000 (not necessarily the $50,000 or $100,000 often depicted as the catastrophic problem) if the family's income is around the poverty line level.

## II. Policy Strategy to Address These Problems

This section presents the broad contours of a policy strategy to improve the long-term care system.

* *Greater coordination and integration of acute and long-term care health coverage*. This would involve devising an incentive structure that rewards the insurer/provider for good health outcomes--recovery from illness, prevention of disease, etc. Crucial to this strategy is the achievement of savings in the acute care health system that are used to extend a greater measure of coverage for long-term care. This is happening now under Medicare risk-sharing contracts with HMOs and CMPs, and is being tested in the Social HMO experiments.

We should also experiment with the coordinated management of health benefits in these key areas:

--Medicare and employer-provided retiree health benefits
--Medicare and Medicaid for dual eligibles
--Medicare and private Medigap policies

* *Payment system reform is a prerequisite to additional financing*; no public official or private sector leaders should be expected to pour new money into a fragmented system, biased toward high-cost institutional care.

* *We need to reform public programs to end the all-or-nothing nature of public policy*. Reforms could be built along two separate lines. First, the Medicaid program could be modified to provide a little better coverage for long-term care in a "vertical" direction--that is, reaching up the income and asset ladder a little bit. The descent into abject poverty that now must precede any coverage under Medicaid for long-term care would be

modified. The fall would be better cushioned, with graduated subsidies and a little bit more asset protection.

Of course, we don't want too much asset protection; you don't want middle and low/moderate income taxpayers paying more taxes to protect the assets of those with greater resources. But between that inequitable situation and today's unconscionable "free-fall" situation, there is plenty of room for reform.

The problem is that it costs money--big money. For a federal government that is already vastly overextended, the thought of a one-step major new financing commitment for Medicaid expansion is probably unrealistic. We also may wish to avoid a welfare concept to a long-range solution for this problem. In the final section of this testimony, however, I present very briefly some financing options that would permit a significant expansion if we decided to establish this as a priority.

I would propose these incremental steps for Medicaid:

--mandate Medicaid buy-in protection for Medicare beneficiaries with incomes below the federal poverty line, irrespective of SSI participation. Medicaid would pay the Medicare premiums, deductibles and copayments for the poor. This step was made optional last year by the Congress. Making this protection mandatory would cost an estimated $300-350 million annually when fully implemented.

--increase the personal needs allowance from its current low level of $25 per month. It is my understanding that CBO has estimated the annual cost of raising the PNA from $25 to $35 at $105 million. Although higher increases might be justified by needs, I would favor starting with this interim step.

--liberalize the income and asset restrictions on a community-based spouse of a nursing home patient. While the asset limit should not be raised too much, in order to avoid horizontal equity problems of asset protection for one household paid for by the taxes of another household with less resources, we could raise current levels somewhat without serious concern. Some proposals now under consideration by the Congress would combine an increase in allowable assets with an increase in permissable income to a level that is twice the federal poverty line for a two-person household. With the exact figure depending on the asset limit chosen, the cost of this step would be roughly $400 million when fully implemented.

--thus, the cost of these three steps, representing an important start in improving the Medicaid program, would total about $800-850 million on an annual basis.

These steps represent a way to improve Medicaid coverage directly by changing some of the Medicaid program parameters. An effort could also be made to improve Medicaid coverage for long-term care by bringing more people into the SSI program and raising SSI benefits. Sheila Zedlewski, Richard Michel, and I have just completed a study on ways to reduce poverty among the elderly and disabled that presents detailed cost figures and financing options for this type of action. This study has been made available to this committee. My own personal recommendation is to take the following steps in this area:

--drop the 209b provision of federal law that permits states to set more restrictive criteria for Medicaid eligibility than for SSI eligibility; everyone who is eligible for SSI should be eligible for Medicaid. States should not be allowed to set higher income or asset thresholds for one program than for the other or define disability and blindness more strictly for Medicaid than for SSI. About 22 percent of the SSI population live in fourteen states that exercise this 209b option.

—develop a more effective outreach program to increase participation in SSI among those who are eligible; only about half of those eligible now participate.

—raise SSI benefits, in stages if necessary, to federal poverty thresholds.

—relax the SSI asset test; note that this is an alternative to easing the Medicaid asset test. It would bring more people into Medicaid through the SSI gate as opposed to leaving that gate shut and allowing more of the those ineligible for cash assistance, but poor, at least to get Medicaid. If we doubled the SSI asset limits, the yearly cost would probably be in the $50 to $60 million range.

—while the precise cost figures for these types of steps depend upon a variety of factors such as which poverty line is used (elderly or overall) and how much the asset test is relaxed, I would estimate that a package like this would cost about $6 billion dollars per year when fully implemented. Of course it would be possible to do this in stages or to fill in the gaps partially instead of fully. A package of helpful changes could be put together at a variety of funding levels. The final section of my testimony lays out the broad contours of some basic options for financing these steps, and the study I have done with Michel and Zedlewski, just published by the Urban Institute, analyzes these financing options in more detail.

* Medicare should be reformed to provide a better measure of protection for long-term care. I do not favor simply adding a major long-term care program to Medicare that starts at the front-end of need and has no coinsurance. I think that the cost of such a "blank check" program would break the federal bank at this juncture, and it would appear from available forecasts that the federal government will be lucky to be able to meet its current Medicare commitments in the early part of the next century when demographic forces really take hold. The steps I will recommend could involve some new spending, but they could also be accomplished through a redirection of outlays, better targeting, and a new approach to Medicare that makes it more of a full catastrophic protection program.

* We should consider adding to Medicare a stop-loss provision for very expensive health care costs - both on the acute and long-term care side. Instead of Medicare only offering generous hospital coverage, reasonably good doctor bill coverage, and very little long-term care protection, as now occurs, Medicare should be more of a stop-loss program across-the-board, providing full protection against financial ruin. With Medicare as a back-stop, there would be much more interest in private sector insurance for long-term care. There would also be less panic in the employer community about maintaining retiree health benefits if the public sector had a finger in the dike.

Currently, the catastrophic debate centers around whether the public sector or private insurance picks up the back end of Medicare's acute care coverage (e.g., the substantial cost-sharing imposed for the proportionately small number of patients remaining more than 60 days in a hospital). While one side acuses the other of wanting to take away its business in the acute care area, both sides run a mile when long-term care enters the catastrophic debate. When it does enter the debate, the options involve some enrichment of benefits or gap filling at the front end, typically tied to institutional care, which still leaves substantial gaps and vulnerability.

* Medicare could provide a measure of back-end coverage across-the-board for acute and long-term care services. Meanwhile, insurers and prepaid plans would likely be very willing to enter this market by providing coverage at the front-end and in the middle in new insurance

and delivery packages. HMOs, for example, may be much more amenable to taking higher risk older persons if they knew that Medicare would serve as a back-stop. Morever, such a strategy would spur the development of long-term care insurance, whose market currently lacks vigor and whose coverage is often insufficient.

* There are two ways that this new federal role can be accomplished. First, Medicare could set up a new entitlement for long-term care, but with a substantial waiting period — say two or three years -- and substantial co-insurance which Medicaid would pay for those who are poor. Second, Medicare could reinsure the private market against very high expenses (e.g. over $100,000).

There would need to be, however, certain conditions to Medicare serving as either an entitlement in this area or as a reinsurer. First, there would need to be a definition of the degree of disability that qualified a person for benefits, one that limited coverage to rather serious levels of disability. Second, there would need to be significant deductibles and copayments to limit overuse. Third, there would need to be some waiting period.

* If Medicare served this role, it would bring substantial fiscal relief to the states under Medicaid. The advantage to such an approach is that the need for elderly persons to become poverty stricken in order to be insured for long-term care would be obviated.

The federal government should turn back a roughly equivalent amount of programs in such areas as economic development and transportation to avoid a windfall to the states. In fact, appropriate expenditure cuts in other areas of the budget would be one way to finance this coverage. Medicare premium increases and/or the taxation of a portion of Medicare benefits, discussed below, would be another.

* If Medicare provided a stop-loss feature, federal outlays would also be saved under the Medicaid program (in addition to the fact that the states would save money). In my view, such savings should be used for steps such as the assured Medicaid buy-in protection. If Medicare "buys out" part of the back end of Medicaid, then the resultant Medicaid savings should be used to enhance coverage for the poor at the front end.

* Ideally, Medicare should be expanded in a service-neutral approach, with the identification of services provided based on the elderly person's need rather than what Medicare will or will not pay for. If the federal government chooses instead to expand specific services, the focus should be on services needed to remain at home, recognizing the quasi-medical or non-medical nature of many of these services. Such services might be funded through the Social Services Block Grant and would include:

—meals
—physical therapy
—psychiatric and psychological counseling
—assistance with intravenous feeding
--bathing
—home safety to avoid accidents
—transportation to doctors' offices
--in short, assistance with daily living

* people should be encouraged and incentivized to save for the long-term care expenses they might face in old age. If Medicare is going to provide a greater measure of catastrophic protection, it is reasonable and necessary to expect people to prepare themselves for the front end. Thus, the system would have three parts--a Medicare backstop for long-term care, a more secure and equitable safety net, and personal responsibility for what lies in between. In other words, the signal sent by government would be as follows: do as much as you can, through insurance and saving during your working years, to prepare yourself for this contingent possiblity. If you get in deep financial trouble, Medicare will be there, either as a stop-loss program or as a reinsurer that protects your private insurer or

prepaid health plan against the catastrophic tail of the distribution of outlays. And, if you are poor, a more equitable Medicaid program will help you. But, the government is not running a national asset protection program for all Americans at all asset levels. So if you want to protect your assets above poverty or near-poor levels, get insurance.

—I would strongly emphasize the desirability of group insurance and encourage the labor-management community to begin to educate the work force and integrate such insurance into a flexible benefit package.

—the concept of individual medical accounts, as outlined by Secretary Bowen, also deserves careful study, along with home equity plans for the elderly. With $700 billion in home equity assets among the elderly, this option should not be cast aside.

* government should roll back certificate-of-need regulation. Greater opportunities for nursing home expansion, coupled with clear quality standards, should be opened up, along with open entry into home health care markets. Also, it is crucial to the potential success of hospital "swing beds" that providers have the flexibility to swing beds back to acute care use when necessary without running into local planning barriers.

* a better data and information system needs to be developed at the local level. In the present fragmented system, no entity has the incentive to develop such a clearinghouse. We need better discharge planning information and better data on patient health status at periodic intervals after discharge. Also important is a centralized knowledge base accessible to the elderly and their families about available services in the community.

* private, nonprofit organizations can play a key role in delivering care, monitoring care, and providing and coordinating information. This role involves the organization of volunteer networks for home visits to the elderly, respite care for spouses and children providing long-term care, and arranging for such services as meals-on-wheels or physical therapy. RSVP programs, the programs of such unions as the International Ladies Garment Workers Union, and other activities are providing the type of caring outreach that enters into the realm that will probably never be fully reached by the medical professional or a government program.

## III. Financing

Any new commitments on the part of the federal government should be fully funded. It would be fiscally irresponsible to add further to the federal deficit, which is already much too high. In my view, the financing source should also be progressive in nature—we do not want to tax one group of relatively needy people to help another group. Moreover, I believe that it will helpful if the financing source bears some recognizable link to the social objective. This means that in financing new commitments to the area of long-term care, we should select mechanisms that are associated with the life cycle process of setting aside money for retirement and health care needs.

Wherever possible, we should recycle and re-target the money that we are already spending in the direction of greater need. This does not necessarily mean budget cuts in one area to finance additional outlays in another area. It could also entail taxing some income that is now untaxed in an amount that is equivalent to anticipated outlay increases.

In my view, the funding mechanism should also promote the concept of generational equity. To the extent that older people are protected against the expenses associated with long-term care, their children and grandchildren will also be helped, and these "beneficiaries" should be willing to help pay. In addition, these younger people will be older themselves, one day.

The following major options meet the criteria just outlined:

- Taxing more of social insurance benefits
- Taxing more of employee benefits
- Taxing estates more heavily
- Raising the payroll tax base
- Cutting government expenditures in ways that protect the needy.

### A. Taxing a greater portion of Social Security benefits

The current method of taxing Social Security benefits counts one-half of the value of benefits as taxable income when certain income thresholds are exceeded - $25,000 for individual and $32,000 for joint returns. One alternative is to tax the amount of Social Security benefits that exceeds the lifetime contributions by employees (which is how private pension plan benefits are taxed). This concept would be approximated by the taxation of 85 percent of benefits with no income thresholds triggering liability. Our new study estimates the revenue gain in 1988 from this step at $11 billion. If 85 percent of benefits were taxed and if the thresholds were lowered to $16,000 and $12,500 (instead of eliminated), the revenue gain in 1988 would be $5.5 billion.

### B. Taxing Medicare Benefits

Another option for broadening the tax base by taxing social insurance benefits would be to tax the portion of contributions to Medicare that is not made by the Medicare beneficiary. Beneficiaries pay one-half of the portion of the payroll tax for Part A of Medicare and 25 percent of the cost of Part B in the form of a monthly premium. If 50 percent of the insurance value of Part A benefits and 75 percent of the insurance value of Part B benefits were treated as taxable income for Medicare enrollees, and the current thresholds for taxing Social Security benefits were kept in place and applied to these taxable Medicare values, an additional $14 billion would be received by the federal government over the 1988-1992 period, according to CBO estimates.

### C. Taxing employee health benefits

Employer contributions for employee health care benefits are currently tax-free income to the employee. One proposal to limit the exclusion would treat as taxable income any employer contribution to health insurance that exceeds $200 a month for family health insurance policies and $80 a month for individual policies (in 1988 dollars, with these amounts indexed for subsequent inflation). Over the five-year period from 1988 through 1992, the CBO estimates that the increase in federal revenues would be $34.3 billion, of which $22.2 billion would be increased income tax revenue and $12.1 billion would be payroll tax gains.

### D. Increasing the payroll tax base

The ~~limit~~ on income subject to the payroll tax in 1987 is $43,800. If this cap were increased to $75,000 for both employer and employee payments, an estimated $13-14 billion could be raised in the first year - 1988. Some of the savings would be offset in future years as a result of new commitments to pay future benefits to higher-income workers. If the base were raised to $75,000 on employer payments alone (a variation of this option that I do not favor), about $7 billion would be raised in 1988 and no added commitments to pay future benefits would be incurred.

### E. Taxing estates

The estate tax base has eroded in recent years as the threshold value of estates that triggers estate tax liability has risen in stages from $175,625 in 1981 to $600,000 today. As a result, estate tax collections began declining in 1981. The CBO estimates that if the estate tax exemption were lowered to $400,000 and held there, and the current tax rate were frozen, federal revenues would increase by $9 billion over the 1987-1991 period.

Also, we could raise new revenue by taxing capital gains at death. Currently, when a person sells an inherited asset, he or she pays capital gains only on the gain since the inheritance; the gain accumulated, but not realized by the decedent is not taxable to the heir (unless it is included in an estate valued at $600,000 or more, where it is subject to the estate tax). Capital gains could be taxed more fully by either taxing capital gains on the decedent's final income tax return or requiring the beneficiary to carry forward the decedent's cost basis (e.g. adjusted original purchase price). CBO estimates that taxing capital gains at death would raise about $20 billion in new revenues over the 1987-1991 period.

### F. Reducing government expenditures

Another way to finance new spending on long-term care is through corresponding reductions in other government expenditures. In my view, the arena in which to begin the search for further expenditure reduction at this juncture is discretionary economic development and assistance programs. This area includes federal programs that subsidize transportation (mass transit, Amtrak), economic development activities (Economic Development Administration, Urban Development Action Grants), agricultural subsidies, community development programs, and Defense Department impact aid to public schools.

It seems difficult to justify the full funding of such programs - or even subjecting them to only marginal trimming - when the types of inequities and inadequate protection documented here persist. Moreover, given the size of the cost estimates presented here for making substantial improvements in our safety net, it would seem quite feasible to carve some of the needed savings from such discretionary programs without gutting them.

Chairman **Stark**. Jack, I have got to admit a prejudice on this idea of mobilizing volunteers in that the last examples I can remember in civilization were the pyramids of Egypt and the plantations of the South. And I always have some feeling about how volunteers are mobilized through history.

Mr. **Meyer**. Well, I had in mind something a little more voluntary than that. [Laughter.]

Chairman **Stark**. Mark Meiners.

## STATEMENT OF MARK R. MEINERS, PH.D., NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND HEALTH CARE TECHNOLOGY ASSESSMENT, U.S. PUBLIC HEALTH SERVICE

Mr. **Meiners**. Thank you, Mr. Chairman, members of the committee. It is indeed an honor to be asked to testify before you today.

I am a researcher and appearing today as such. I am with the National Center for Health Service Research, which is part of the Public Health Service.

I will be presenting information in my testimony, which I will summarize here, which is based on about 8 years of research in the area of long-term care insurance.

Private options for enhancing the resources of the elderly and mobilizing them to help pay for long-term care has, until very recently, been largely unexplored. This is important to keep in mind as we think about how to finance long-term care. Insurance, which is the major vehicle for financing health care privately was generally perceived as not applicable to long-term care. As a result, private financing mechanisms for long-term care did not receive much serious attention.

This situation has clearly begun to change with considerable activity and interest around the country in developing private financing options.

In 1979, we at NCHSR began a multifaceted study to determine whether and under what circumstances there might be a market for private insurance for long-term care. That study produced research results, suggest that a reasonable case can be made for such a market and that there are data which could be used to help us experiment with the features of prototype policies. In the process of doing that research, we also found a few insurances offering insurance benefits that provided long-term care protection.

We also did some survey work that suggested that there was a lot more consumer interest in this area than had previously been thought.

We believe that our research has helped to stimulate the insurance industry to adopt a more positive attitude about the potential of risk pooling mechanism to insure long-term care and has stimulated further research and development.

Three basic models of long-term care insurance are capturing much of the attention. One model is the free-standing, long-term care insurance product. Another is the social HMO model. A third model is the continuing care retirement community. Each of these represents different degrees of comprehensiveness of the benefit package as well as differences in the management of risk and the organizational structure.

It is the free-standing product that has captured much of the attention; it is the model you are hearing the most about. This is because it focuses directly on the long-term care risk. The other two options are broader in their focus, integrating the long-term care risk with acute care in the case of the social-HMO and including sheltered housing in the case of continuing care retirement communities.

In focusing on the free-standing model it is easy to find fault, as has been noted already. Most of the products tend to perpetuate the institutional bias, although there has been some movement very recently to try to expand into home and community care benefits.

The products that are out there do have risk management techniques that can be fairly restrictive and the better ones, while not exorbitant, are also not cheap.

These factors have served to limit the market for this kind of protection. Nonetheless, there are free-standing products available that deserve serious attention by those who can afford them.

By focusing on the nursing home risk, they address the major cause of catastrophic health care expenses among the elderly. For the elderly, out-of-pocket expenses on nursing home care approximately equal the out-of-pocket expenses on all other health care services.

The limits and restrictions that we find in these products are a function of a conservative industry that is entering a new unexplored product line. As more insurers enter the market, competition will encourage better benefit packages and more affordable premiums.

We have already begun to see broader benefit packages being offered. I also believe that we can expect to see linkages with other risk pooling mechanisms that will create more comprehensive products that can take better advantage of managed care and offsetting risks. Further research will be necessary to achieve the full potential of private long-term care insurance.

I think that some of the areas of development that we should be encouraging include what I would call Medicare super supplements; medigap policies designed to include some long-term care benefits.

One example of this type of development is Medicare HMOs getting involved in test marketing long-term care benefits to their members.

Reinsuring retirement communities for their chronic care guarantee is another area that is beginning to receive attention from insurers. Also, similar but less expensive continuing care programs designed to help people remain in their own homes and yet have access to comprehensive long-term care benefits are under development.

There are also links with life insurance and home equity conversion that are beginning to be considered.

The development of a market for long-term care insurance potentially has benefits for both consumers and the Government to the extent that spend down can be delayed or avoided. Fostering that development from a public policy standpoint can take place in a variety of ways.

Consumer education is extremely important. Letting the consumers know that Medicare and Medigap policies do not cover long-term care is important. As products develop, it will also be important to give consumers guidance about what to consider when purchasing this kind of insurance.

There is also a need to review the regulatory environment in which these insurance products are developing, so that appropriate development is not inhibited.

In addition I think it will be useful to closely examine the cost and care management programs already in place with the Medicaid system with an eye toward the possibility of integrating those systems with those needed for the private market products.

Other strategies that involve more direct market support include premium subsidies, a waiver of spend down rules, and reinsurance programs designed to encourage insurers to more rapidly expand the market.

It is clear that the market is in its infancy and there is room for substantial program and policy development, but I think that it is a wise first step to support that development.

Thank you.

[The prepared statement follows:]

## Statement of Mark R. Meiners, Ph.D., National Center for Health Services Research and Health Care Technology Assessment (NCHSR), Department of Health and Human Services

Mr. Chairman, and Members of the Subcommittee, it is an honor to appear before you today.

I am here as a researcher. I work for the National Center for Health Services Research and Health Care Technology Assessment (NCHSR) which is part of the Public Health Service. I will be presenting information on long-term care insurance based on my involvement with research on this topic over the past 8 years.

### BACKGROUND

Private options for enhancing the resources of the elderly and mobilizing them to help pay for long-term care had, until recently, been largely unexplored. Insurance, the major vehicle for financing health care privately, was generally perceived as not applicable to long-term care. As a result private financing mechanisms for long term care did not receive much serious attention.

This situation is beginning to change. In 1979 the National Center for Health Services Research undertook a multifaceted study to determine whether and under what circumstances a market for long-term care could exist. This study has produced research results which have shown that a reasonable case can be made for long-term care insurance, that data are available to begin to examine alternative prototype benefits, that a few insurers were actively involved in selling such coverage, and that there was more consumer interest in such insurance than was first thought.

Through various publications and presentations the NCHSR research has served as the catalyst to further research and development. We believe our findings have helped the insurance industry to adopt its current, more positive attitude about the potential of risk pooling mechanisms to insure long-term care and stimulated further inquiry into ways to finance those options.

### NO ONE MODEL

Three basic models of LTC insurance are curently being marketed—free-standing LTC insurance, Social-HMOs, and continuing care retirement communities (CCRCs). The approaches differ along a variety of dimensions including the comprehensiveness of the benefit package, the management of risk, and the organizational structure. Free-standing LTC insurance is the most generic of these models in that it focuses on the long-term care risks alone. The Social-HMO model expands the concept by integrating chronic care benefits with acute care benefits in a managed care environment. The CCRC model (in its broadest configuration) expands the concept further by providing sheltered housing as well as a comprehensive health care guarantee. No one model may be best for everyone. Each is undergoing testing, revisions, and further development. However, it is the free-standing type of product that has captured much of the initial interest in the insurability of long-term care and it is this approach I have been asked to discuss here today.

## FREE-STANDING LTC INSURANCE

Medicare and Medigap insurance policies are intended to cover only acute illness or post-acute recovery. In contrast, free-standing LTC insurance is an insurance policy that provides for the payment of care in an institution, the community, or an individual's residence when such care goes beyond the Medicare definitions of care and when the policy holder is not locked into a particular provider system. Implicit in this definition are two very important distinguishing features. As noted, chronic illness rather than acute illness or post-acute recovery is the focus of the insurance so the benefits are designed to address the need for personal assistance with basic activities of daily living (often termed intermediate or custodial care) in addition to skilled nursing and therapeutic services. Also, the benefits are designed to pay for an extended spell of illness. These are the key features that distinguish long-term care insurance from the acute care related nursing home and home care benefits of Medicare and Medigap insurance.

There are several reasons why the free-standing type of product has captured much of the initial interest in dealing with the problem of financing long-term care. By focusing on the long-term care risk alone it is easier to define what constitutes the insurable risk. Under this approach one can specify the features of the policy and provide a clearer description of the benefits to potential buyers. It also makes it possible to market the insurance as a new product rather than a modified supplementary Medicare policy that then must compete against the cheaper Medigap policies which are widely available and which have been purchased by about two-thirds of the elderly.

The market for free-standing LTC insurance is still new and not well developed. About 25 products are now being sold and many have only become available within the last year. Information on the number of policies sold is difficult to obtain but estimates are in the range of 200,000. Most of the policies have been sold on an individual basis although some are marketed through groups.

Until recently most of the insurers involved in selling this kind of protection were small companies. This has begun to change, however, and some of the largest insurance companies are in the process of developing and marketing their own products.

The specific features of the policies available now differ but they have a number of things in common. Most cover nursing home care at the skilled and intermediate levels. A few also offer custodial and home health care benefits but typically these benefits are limited and sometimes only available under an optional rider. Benefits are structured as fixed amounts per day with waiting period as long as 100 days before benefits begin and there are limits on the coverage period of anywhere from 2-6 years. In adition to emphasizing institutional care and carving out a segment of the long-term risk, a variety of techniques (see Table 1) are used to manage the risk.

TABLE 1.—FREE-STANDING LTC INSURANCE RISK MANAGEMENT TECHNIQUES

Prior hospitalization required—usually 3 days
Nursing home occupancy must begin in 14-90 days—30 days most typical
Must be same illness or injury that caused the hospital stay
Physician recommendation and review of care required
Screen sales for pre-existing health conditions and prior hospital or nursing home stays—time periods vary
Exception to coverage, e.g., care outside U.S., expenses due to war, self-inflicted injury, mental disorders
Premium adjustments possible
Renewability may not be guaranteed
Service definition important especially if they determine length of coverage and benefit levels

The premiums are age rated, with the rate fixed at the time of purchase in most cases. The actual premium rates vary widely among products depending on the age at time of purchase, the features of the policy, and the expense-loading charged by the insurer. One recent review of several of the available products, published in *Money Magazine*, indicated a 65 year old purchaser should expect to pay $174 to $1,451 a year for policies that cover skilled and custodial care.

In assessing the free-standing products currently available it is easy to find fault. Most tend to perpetuate the institutional bias that prevails in our public programs, they use restrictive risk management techniques, and the better ones, while not exhorbitant are also not cheap. All these factors serve to limit the market for such protection.

Nonetheless, free-standing products are available that deserve serious consideration by those that can afford them. By focusing on the nursing home risk, they address the major cause of catastrophic health care expenses among the elderly. For the elderly, out-of-pocket payments on nursing home care are about equal to out-of-pocket payment on all other health care expenses combined.

The limits and restrictions are a function of a conservative industry entering into a new and unexplored product line with little hard information to guide them. As more insurers enter the market, competition should encourage better benefit packages and more affordable premiums. I believe we can also expect to see creative linkages with other risk pooling vehicles to achieve more comprehensive coverages that take advantage of managed care and offsetting risks.

## FURTHER DEVELOPMENT NECESSARY

Further research and development will be necessary to achieve the full potential of private market LTC insurance. Comprehensive products sold to groups before retirement that use some form of managed care environment are good candidates for overcoming the major barriers to such a market. Insurers should be encouraged to offer Medicare supplemental options that include long-term care benefits. The interest on the part of some Medicare-HMOs in offering LTC insurance to their members is a move in this direction worthy of note.

Further opportunities to expand the market for LTC insurance include reinsuring retirement communities for their chronic care guarantee and developing similar risk pools among community members preferring to stay in their own homes. Both these strategies are appealing because they involve group sales where all parties to the agreement work together to control the risk in a managed care environment that includes the home setting.

Strategies for market expansion might also involve links with other financing vehicles such as home equity conversion or life insurance to take advantages of offsetting risks while promoting recognition of the need for long-term care protection. Other strategies involve tax preferences for individual savings accounts dedicated to the purchase of LTC insurance or for encouraging employers to offer such protection as a retirement option. Although the current fiscal environment is not encouraging for tax incentives, the need for protection against the catastrophic expenses associated with long-term care may lead people to conclude that these strategies may warrant special consideration.

## POSSIBLE PUBLIC POLICY ROLES

One of the most intriguing aspects of LTC insurance is the potential it holds for relieving some of the pressure on Medicaid. Government payors will benefit if private insurance can reduce the role of Medicaid as a source of payment for middle income elderly by delaying or avoiding the need to spend-down their resources. It also may be viewed as an alternative to the current incentives to transfer assets to gain eligibility. The possibility that there could be savings to public budgets as well as benefits to consumers suggests that there is a public role in encouraging the market.

A variety of public policy interventions to support the emerging market are possible. A relatively inexpensive yet extremely important role is that of consumer education. Further efforts are needed at both the Federal and state level to inform consumers that Medicare and most private insurance policies do not provide extended care benefit for chronic illness and disability. As products become available, consumers will also need information and guidance to make informed choices. States in particular can play a significant educational role through the office of the commissioner of insurance. They can also encourage insurance regulators to assist the development and marketing of such benefits by removing regulatory restrictions that inhibit reasonable product experimentation. Significant additional support for market development may be achieved by coordinating the cost and care management mechanisms of public long-term care programs with those that the private market views as important to its success.

The significant role states have in financing long-term care, along with having been delegated much of the responsibility for the structure and administration of long-term care programs also provides the incentive for more direct support of the emerging insurance options. In particular, states should carefully evaluate their current role in financing long-term care. The rules governing eligibility for Medicaid through the spend-down process should encourage the use of an individual's resources for their own long-term care.

Medicaid cannot afford to act as inheritance insurance for heirs and a private LTC insurance market cannot fully develop if Medicaid plays this role. At the same time it is important to recognize that there are situations where Medicaid rules may stand in the way of sensible support. Spousal impoverishment brought about by the deeming rules in some states is an example of this. In structuring interventions to deal with such problems consideration should be given to incentives that encourage private initiative and responsibility.

More aggressive strategies involve direct market subsidies. There are strong reasons for considering such interventions in the market. Long-term care insurance is in its infancy. While there has been considerable interest in product development the market is small and underdeveloped. Until there is more experience with insuring long-term care we can expect progress to be slow and conservative. The limited market size and conservative pricing in turn tends to restrict the market to relatively high income persons. It is in this context that strategies to subsidize the market may make sense. By targeting subsidies to persons otherwise unable to afford the insurance the market size is increased and greater numbers of those most likely to spend-down to Medicaid are included.

Market subsidies could take several different forms. One approach would be to guarantee full protection from further asset spend down for anyone paying through insurance or out-of-pocket for a set number of years. This would address the concern that current policies do not offer complete catastrophic protection; the maximum coverage being about 6 years. A disadvantage of this approach is the potential of public dollars being spent on relatively well-off individuals.

Asset waiver strategies are based on the assumption that a major barrier to market development is the desire for asset protection. While this may be important, it is also likely that the current market faces affordability constraints which loom at least as large as a barrier to further development.

Premium subsidies in the form of tax credits or deductions if a person buys a State certified level of insurance protection is another way to support market development. This type of subsidy could increase the affordability of current products. Both asset waiver and premium subsidy strategies are targeted to the consumer and could be varied on the basis of income.

Other subsidy strategies could be in the form of premium tax breaks or public reinsurance programs targeted to help insurers overcome their hesitancy to enter or expand the market. Carefully crafted, a state reinsurance program could serve as the basis for a data collection initiative that could help overcome insurers hesitancy to share information on utilization and cost patterns under their programs. The lack of such data has been perceived as one of the barriers to more rapid market expansion.

Assistance to market development might also be accomplished by paying the insurance premium for persons eligible for Medicaid on the basis of low income. This would serve to broaden the risk pool and help spread administrative costs.

There is no one approach to supporting the market that is obviously the best at this stage in the development of the market. Depending on specific market characteristics and its particular objectives a State might choose to use one or several of these strategies to encourage development of this type of insurance. the uniqueness of a state's Medicaid eligibility criteria in addition to its regulatory approach to long-term care insurance will drive state initiated efforts to conform with the constraints they impose in other areas. In addition, a state's own fiscal outlook and political climate will play a role in determining whether strict budget neutrality will be the measure of feasibility and success or whether the benefits of a more workable method of paying for long-term care will be viewed as worthy of more resources.

## CONCLUSION

The need for long-term care is the single most important cause of catastrophic health expenses for the elderly. Although this fact was noted nearly 10 years ago in a report by the Congressional Budget Office, it is only recently that it is receiving much attention. Perhaps the reason for the previous lack of recognition was that there was no alternative short of a National program and that has repeatedly been avoided as too costly. It made little sense to alert the public to the significant financial risk associated with the need for long-term care if there was no workable soltion. A break in this stalemate has occurred with the recognition of long-term care as an insurable risk. The new private financing initiatives have begun to show how the risk can be shared in a way that encourages individuals with resources to participate in risk pooling and in the process help clarify those areas where there will be a need for public involvement on behalf of individuals without adequate resources.

The development of LTC insurance is in its infancy and there is a need for improved data on virtually all aspects of that development including information on utilization, costs, risk management, marketing, and the impact of such coverage. At the current time it seems that supporting this development is a wise first step. There is sufficient uncertainty about long-term care needs now and especially in the future that a pluralistic approach makes considerable sense; particularly when the possibility of continued stalemate is likely. As we learn more about how to insure long-term care other, bolder, strategies may suggest themselves.

Chairman STARK. Thank you. Let me just try a few generalizations and see what kind of concurrence the panel would have.

I am going to divide the current 30-plus million Medicare beneficiaries into three groups and guess that I am not far off.

The top third being those who, guessing by their present income, would have been able, during their working, productive careers to accumulate enough additional assets to provide for their own care either through savings or some assistance in spending in the down part of their real estate equity or most things and that the private voluntary family assistance would pretty much take care of those people.

The middle third would probably need a combination even though they were thrifty and frugal. They still might not make it.

And the bottom third are going to need tremendous assistance. I mean, we do not turn them out into the streets. They may not get very good care.

Am I far off? Is that a fair kind of assumption?

Mr. WIENER. I think that is a fair description of the general elderly population, but as Bruce pointed out, it is not the general elderly population that ends up in nursing homes.

Analyses that we have done would suggest that, for example, about three-quarters of all Medicaid expenditures are for people with incomes of $7,500 or less.

From the public perspective, that is where the money is going. But in general I think your characterization is accurate.

Chairman STARK. Mark.

Mr. MEINERS. Well, I think part—just to expand on the answer—I think part of what we have to keep an eye on though is the fact that people get to be 85, there is some depletion of the income and resources just as a normal life course savings and consumption patterns.

And what we need to think about doing is trying to reorient those to try to make sure that this long-term care risk is recognized as something that is a significant part of the aging process.

Chairman STARK. So, what you might say is that by the time people get to be in their eighties, there are two groups, two-thirds in the lower class of the income scale who are going to need a lot of help and one-third who can still manage to make it on their own.

In other words, the top group stays fairly flat, but the middle class kind of spends down as they just go through the process of living until they may need long-term care.

Mr. **Meyer**. I think your description is accurate. I think the problems lies mainly with the low moderate income people, the bottom half of the middle third and the top half of the upper third of the income distribution.

This a problem generally in our society. These people are not eligible for Medicaid. And I have suggested that in my view, the answer to that is not Medicaid expansion into the middle third.

We ought to get the two-thirds of the people that are poor and not on Medicaid on to Medicaid some way, or at least many of them. But the people just above the poverty line are not going out to buy IRAs and they are not going out to buy IMAs, if we put in IMAs, and so on.

They make $10,000 to $15,000 a year, maybe $20,000 while they are working. They are not protected, and I think we need some kind of a group insurance mechanism, perhaps with a flexible subsidy. Maybe they would get a small subsidy if they were in the $10,000 to $15,000 range, with a more complete subsidy at lower incomes.

And I like the idea of some kind of back-end Medicare protection, so that every one would be in the same group in this sense.

I worry about segmenting the population for adverse selection reasons. You might load up the private group with all low-risk people and the public group with all the high-risk people. And I think you have accurately portrayed the groupings.

Chairman **Stark**. Again, the private insurance idea might make it more efficient for the top half of the total population, certainly the top third, and do nothing, probably for the bottom third and muddle along in the middle.

And there are, so far as we can see, those choices. I mean, there is something like Medicaid—I will ask about that later—and a variety of savings programs which perhaps we could make more efficient. But for the top and the middle it is catch as catch can.

It has been suggested, and I am talking about this necessarily in a jurisdictional issue, but does the panel see any great advantage in literally combining Medicaid and Medicare and making it kind of a continuous function so that it does away with some of Jack's objections—or is that a matter of indifference to each of you?

Mr. **Wiener**. Well, I think if you are going to combine Medicare and Medicaid, you have to radically change what the Medicaid program is.

I do not think anyone is going to be fooled by just relabeling the Medicaid program the Medicare program. It seems to me that if you want to do that, the very first thing at least you would want to do again is raise the level of financial protection that the program offers.

You can still have a means tested program without leaving people with 75 cents a day and making it a major question of whether or not they can afford a newspaper each day.

The other thing I think you need to do would be to raise the reimbursement rates. Medicaid rates tend to be substantially less than Medicare rates and I think quality suffers as a result.

Mr. **Meiners**. Well, I think that certainly notions of trying to encourage people to put aside resources for retirement is important in the context of adjustments to improve a program like Medicaid. Incentives that encourage people to put aside the resources and to participate in risk pooling mechanisms targeted to taking care of this lifetime risk are necessary.

People do have to recognize their potential for a longer life span after retirement and the associated risks of needing long-term care—and as much as possible reorient their thinking to put aside some resources for that longer life.

In the context of incentives for private initiative—as you work on revision to Medicare and Medicaid—keep in mind the bigger picture—and the fact that you do need to recognize the importance of private initiatives. To the extent that Medicaid, for example, becomes a much stronger program, the incentives for people to protect themselves are reduced. And we should not lose sight of that.

I do not know that I have an answer for how to proceed, It is a difficult dilemma that we need to struggle with as we go forward in rethinking these programs.

Chairman **Stark**. It escapes this legislator as to what you do for incentives to save for long-term nursing. I mean, certainly, I could not have dreamed up legislating programs for reducing cholesterol levels.

Yet, look at all those people out there jogging up and down on the Mall, who were not there 10 years ago and I do not think the Government had anything to do with it.

If it suddenly became the vogue in this country to save—but I do not think it is. I do not think it is any fun. As I have said before, it is a lot of fun to invest in a condo in Ocean City. You can go over there and barbecue in it and play in it and have a lot of fun on the beach.

But an insurance policy? What do you do with that on the weekend? You cannot cuddle up next to it and read a good book. And as I say, somehow that is not in our—the Americans—I do not make any moral judgment on this. We are just not instinctive savers.

When we do go like crazy is when we get some kind of tax sheltering. That is kind of an immediate gratification, but I am not sure that——

Mr. **Meiners**. Well, people are jogging to improve their health and for various other reasons. I think as we age we need to recognize that the chances of living longer is great. The chances of living longer and being disabled also increases.

Chairman **Stark**. I do not think Government is going to encourage it. That is what I am saying.

Mr. **Meyer**. One thing you could do and I think you are trying to do is to stop the Government dissaving which uses up so much of what little saving we are doing.

It is the Government deficit that makes our low savings rates particularly bad. I wanted also to comment on your question, which I thought was an intriguing one about bringing the two health programs together.

I think there is some merit to doing that with a graduated subsidy and I think there is some merit to bringing all the funds into the social insurance trust funds.

Frankly, also, if more of social insurance benefits were taxed, they could then be used to help people more readily than in the current situation where you are thinking that the expenditures are out of general revenues, while the money coming in is in a trust that is inviolate.

And I am sort of intrigued with maybe even folding SSI into a minimum social insurance benefit so that we will have a solid safety net. We will fund that by money coming in that people are paying for as they work and by taxing benefits.

And we would not have today's situation where only half the poor who are eligible get SSI, and only a third get Medicaid. In other words, we would strengthen the social insurance fund and use the revenues to meet needs such as long-term care or even cash assistance.

And that will not be done over night, but I think it is an intriguing idea and I think it would have the additional benefit of ending the welfare image of a long-term care program.

Chairman STARK. While we do that, would you all comment on a couple of proposals. I have one and the details are pretty flexible at this point, but in terms of dealing with this spousal impoverishment problem, would you also say that that is a fairly high priority item if we are going to tinker for a while before we resolve the whole thing?

Mr. MEYER. Yes, and clearly what I was just saying has a very long-range vision, and I certainly believe in getting on with incremental steps.

I think that this committee has envisioned setting the limit for the income of spouses of nursing home residents at twice the poverty line instead of the poverty line, and I support that, I would also favor some relief on the SSI asset test side—I think that is important.

I think the personal needs allowance is very very low at $25. I believe there has been a proposal to raise it to $35. CBO, I think, is costing that out.

I have mentioned the SSI asset test, which screens people out of the Medicaid as sort of the first gateway. The study that I did with the Urban Institute indicates that for about $50 million in the first year you could roughly double that dollar asset test limit. And that would help this problem.

And, finally, I think you have envisioned the Medicaid buy-in of Medicare's coinsurance, deductibles and premium expenses for very low-income Medicare recipients with some of the additional Federal revenues from taxing Medicare benefits, and, yes, I think we ought to proceed on those steps.

Mr. MEINERS. I view strategies designed to relieve the problem of spousal impoverishment like a subsidy to the deductible for Medicaid eligibility. Currently you have to spend nearly everything before being eligible for Medicaid. The typical situation is when the husband goes into the nursing home and all the resources are in his name and they all get spent leaving his spouse in poverty. Now there are proposals to allow some more reasonable splitting of the resources.

What that essentially is, and I think it is helpful to begin to think of it this way, is a subsidy to a deductible period. In essence, you do have to spend something, but not everything to gain access to Medicaid assistance.

While I am not far enough along in my thinking to say how to make the linkages, it does seem this type of intervention could be packaged with other incentives to encourage private responsibility for financing long-term care needs.

It seems to me that we need to recognize the various components of the long-term risk and recognize that most of the spousal impoverishment proposals are essentially a subsidy of the deductible period which is only part of the total risk.

Mr. **Wiener**. I endorse those proposals. It should be noted that there is an historic tension within the long-term care component of Medicaid as to whether or not the program should solely be for officially poor people or whether it should also provide a safety net for the middle class.

Those proposals are all in the second tradition and not the first. I think that is fine, but we need to be aware that there is that tension in the program.

Chairman **Stark**. Mr. Pickle.

Mr. **Pickle**. I think we are all intrigued by the possibilities that might exist in these areas.

I noticed none of you have mentioned anything about the cost. I realize it would be difficult to put a finger on that, because it depends on the program and the kind of approach you use.

But what are we talking about, if we give coverage for long-term care? Are we talking about costs, both private and government, however we do it, of $5 billion, $15 billion, $50 billion? What do you think the cost is going to be if we cover long-term care?

Mr. **Meyer**. Well, I will just briefly start. I think Josh has done a lot of work on that himself.

I think there are three levels of costs that we can consider. First, the kinds of items we were just discussing, which is filling some of the cracks in the safety net.

In my testimony, I estimated that a package like Mr. Stark was talking about might cost about eight-tenths of $1 billion—of meeting these immediate needs, the personal needs allowance, spousal impoverishment and the Medicare buy in.

I know your question went beyond that, but I just wanted to indicate that for—between three-quarters of $1 billion and $1 billion per year, you could help a lot of already poor people in need.

Second, I have indicated—I have submitted to the committee some cost figures on relaxing SSI. We estimate that raising SSI benefits to the poverty line for senior citizens and the disabled would cost about $5 to $6 billion in current dollars.

It would lift about a million and a half people out of poverty. I have suggested ways to pay for that.

Now, for the most troubling part—the ongoing payment of long-term nursing home care and home care. I am going to be brief and yield to Josh who has done a couple years worth of work on this, according to my thinking, we should set a back-end stop loss, and you could almost set that anywhere.

You could say, "Well, we have $5 billion to spend and no more. That is what we think we can internally finance, so we will set the stop loss at $80,000," or whatever it would be.

Or if you only have $3 billion, you might have to set it at $120,000 and so on.

But you are absolutely right, I think in the implication of your question, you are quickly into at least $5 to $10 billion range and many of the full programs that would cover everything, I would guess, would be into the $20 to $30 billion a year range. But perhaps my colleagues could fill in some of the details on that.

Mr. Wiener. I would make several points. First of all, the question is not whether we are going to pay for long-term care, because we are. But none of the proposals that are on the table, be they public or private, will substantially reduce the expenditures for long-term care in the future. So, the question is how we are going to pay for it.

Second, we start with the current Medicaid program and Medicare, already paying for about 50 percent of total long-term care costs, so anything you do increases it on top of that.

Most of the public programs that we have simulated account for about 75 percent of total long-term care expenditures. So, we are talking about probably about a 50 percent increase in public expenditures for a relatively full program.

Now, the question is how do we pay for it, especially if we are going to have to pay for it one way or the other.

I think the most important thing to do is to try to build up reserves for the baby boom population as we are doing with Social Security.

We have a very long time before those baby boomers hit the nursing home and if we build up those reserves, the tax rates on the working population over that 60-year period does not have to be that great.

We have estimated that a quite comprehensive program—more comprehensive than I would support—could be financed with a 2.5 to a 2.8 percent payroll tax.

To finance projected Medicaid expenditures and Medicare expenditures for the current program that we have in place in now, if you were to do it on a payroll tax basis, would require 1.6 percent of payroll.

It is not trivial, but it does not have to be overwhelming if we get those reserves in place.

Mr. Meiners. From my perspective the notion of cost is certainly underlying the whole interest in private financing options.

As I note in my testimony, long-term care is the primary cause of catastrophic for the elderly. This is not a new issue. It was noted years ago, better than 10 years ago, in a CBO report.

But what we do about that is the real question and it has always been a stalemate situation. There really has not been a very good approach.

Now, at least, we have some ways to begin to think about encouraging people to put aside resources on their own and how to manage the risks associated with long-term care.

I think we have begun to lay the groundwork for better understanding of how to take care of the problem in that context, I support the notion mentioned earlier of doing demonstrations. We are still in a situation where we need to learn much more and demonstrations can help in that regard.

I favor demonstrations at the State level as an important thing to do. As we learn more about how to insure long-term care, perhaps bolder strategies are awaiting us.

At this time a pluralistic approach—an incremental approach seems to make some sense.

Mr. Pickle. I think that the reason we have not entered into long-term care is because we do not know what approach to take, but mainly because it is going to be so very expensive. To me, you are trying to give a sort of sugar-coated answer that coverage really will not cost that much, less than $1 billion. It seems to me like it is going to be much more.

Perhaps you ought to roll Medicaid into the Social Security program.

The tax now is at 7.15. If we do the things you are talking about, and it cost in the neighborhood of $20 or $30 billion, that means your tax would go up to a total of between the two of over 15 percent.

There is going to be a limit that you are going to reach on that. You will be paying over 15 to 20 percent on Social Security tax. Are you recommending that you might raise your Social Security tax from 7.15 up to 8 or 9 or 10 percent?

Mr. Meyer. No, I am not. In fact, I am very worried about the impact of rising payroll taxes on employment, even the level of increase that was being discussed a moment ago.

Bear in mind the three-quarters of a billion figure that I gave you, to one billion, was clearly mentioned as a short-term step. I did not say that that would be the cost of these longer term reforms.

I also mentioned when I suggested converting some of these programs from general revenue to a social insurance trust fund that you would combine that with a greater rate of taxation of benefits.

The CBO has estimated that the five year revenue take from taxing Social Security benefits the way we tax private pensions would be $74 billion into the fund over and above what is now coming in, that is over the 1988 to 1992 period.

What I am suggesting as a possibility for long range reform is bringing more revenue into the fund from those relatively well-to-do or somewhat better off elderly people in order to fill in some of the cracks in our safety net.

Mr. Pickle. Isn't the cap of $48,000, roughly, under Social Security?

Mr. Meyer. Well, the payroll tax is levied on income up to $43,800 and I believe that Social Security benefits are taxed at income over $32,000 for couples and $25,000 for individuals. And as I say, I have developed some cost estimates in this recent study that show that if those thresholds were lowered to $16,000 and $12,500, You would bring in $5.5 billion in the first year. Now that could help some of our senior citizens in need. There are obviously other ways to finance it. We could tax estates more than we do now.

We do not tax anybody's estate unless they have $600,000, as you probably know. That could be changed. We could lower that to $400,000. CBO has estimated that that would bring in, I think, about $9 billion over a 5-year period.

There is a lot of untaxed income out there and there are a lot of unmet needs, and I am just trying to suggest some ways to bring those together over time.

Mr. PICKLE. Mr. Chairman, I know my time has expired and I am not going to pursue this further, but let me make this observation. It is enticing to think in terms of financing this program by raising the Social Security tax for both Social Security and Medicare.

But with the tax level now at 7.15, long-term calculations, accountability, that just keeps us in balance—there is going to be a temptation, particularly in times of budget restraint, to reach out there and get that extra money from Social Security.

We just barely are being accountable for it now on a 75 year basis. But as that surplus grows, people are going to want to get their hands out there and grab that money.

And now you are saying, "We are going to raise it," or "We will raise the threshold from the $25,000 level," or "We will tax that Social Security not at $48,000 but at the total amount."

I think we better think in terms of maintaining a good solid Social Security base. And Medicare is going to be met with considerable opposition and skepticism.

It may be easy to raise the tax on Social Security, but we are in the neighborhood of 14 to 15 percent now and I think people better realize that there is a limit to what you can actually do with Social Security.

I know that is an issue that is going to come up later, but I just wanted to raise it, Mr. Chairman. Thank you.

Chairman STARK. Jake, I think you are right. I think that it is important, to repeat from Jack's standpoint, that a lot of the tax he was talking about deals with the taxing of the benefits, not raising the payroll tax, which I think he agrees with you is already high enough.

Mr. PICKLE. I just got that last part. I do not want you to leave the impression that I was talking in terms of taxing the benefits, either, Mr. Stark.

Chairman STARK. No, I understand how you feel about that, too. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman. And Mr. Pickle, if I may, I just want to pick up where you left off in your questioning.

Mr. Wiener, you testified, and I very much agree, that we need to establish reserves from current incomes, so that those assets are there in the future when they are needed, and are growing, because of the liability that is being created by the so-called baby boom generation today.

I am concerned, however, and I want to test my view on you, and see if you agree. The other panelists should be sure to pitch in too. My concern is that we are actually not creating any reserves—that we are creating a book entry but there is no money there.

I say that because the Social Security trust fund is being invested in Government securities, which means that we are borrowing those funds for current operating expenses of the U.S. Government.

We are spending these funds on today's expenditures. So the money does not exist anywhere. It is being spent.

Now, when we are no longer able to pay as we go, but have to draw on those reserves, those funds will have to be raised from some source to repay the obligation created today. And those sources are limited to taxes, or more borrowing.

And either I am nuts or we have a real problem because of what I have just described.

I do not expect you to tell me I am nuts, but am I off base? Are you concerned?

If you took the funds in the Social Security trust fund, the so-called surpluses—and we ought to get a stick after anybody that calls it a surplus, because actuarially it is an incredibly underfunded plan—the surpluses are not being invested, in my view, in anything that is going to give a return on that investment. If you bought stock, then you would have something, you would hold something of value, and it would be there at the time you need it. But in this case it is not. Am I all wet?

Mr. WIENER. No, I do not think you are all wet. I think you raised a very good issue. I have two comments.

One is that I think it is the unanimous view of the economists at the Brookings Institution that we need to get the overall deficit down so that we are borrowing less, and that is a major priority for the economy.

To your specific question, I really do not have the answer to it, except that the Brookings Institution recently received a contract from the Social Security Administration to look exactly at this issue. Henry Aaron, Barry Bosworth, and Gary Burtless will be examining this over the next year, and I would hope would come up with some sensible suggestions on what to do.

Mr. CHANDLER. Yes.

Mr. MEYER. Well, I think that the Social Security, the OASI trust fund looks a lot sounder to me than the HI trust fund for Medicare. That may be, in your sense, little consolation, but I think we have to say, at least as Congressman Pickle pointed out, there is a precarious expected balance, or a precarious actuarial soundness in OASI over the next 50 years as a result of the 1983 law and the changes made.

Medicare is I think in much deeper trouble when we get to the early part of the next century. That is, we could not even afford current benefits. Now that is why I would be a little careful about adding a major new long-term front-end coverage to Medicare now.

I guess, to get to your specific question whether this precarious balance turns out to be sustainable depends very heavily, it seems to me, on mortality rates and economic performance.

That is to say, I have seen some estimates of where we will be, and if economic performance is good and mortality rates are about as expected, Social Security will probably be all right as it is presently funded.

On the other hand, if we get the kind of growth we have had in the last 10 years, or 15 years, instead of the experience of the two decades following World War II, or we find a lot of medical breakthroughs and people live longer, we would have to raise tax rates or raise the base to make things go.

Frankly, I am not as troubled as you are by investing the surplus in T-bills or other government financial instruments. I would not want it to lie fallow, certainly, but I would not want it invested in too risky a fashion, either.

Buying T-bills and bonds cushions the impact of the dissaving in the rest of the Federal budget. In fact, we would be in big trouble in the next few years if we did not have some net saving in the OASI Fund to offset the dissaving in the rest of the Government.

But I am a little nervous about sort of turning it over to Wall Street, too; I fear an attitude of, let's see what the sexiest stock might be, and go for that. I do not think you were suggesting that.

Perhaps somewhere in between T-bills and a high-flying stock we might find a portfolio that would give a little better return without too much risk. But I would be a little bit nervous about getting too risky with those funds.

Mr. CHANDLER. Did you have a comment?

Mr. MEINERS. Basically, just to comment that I think it is a very real concern, and I guess in the context of what we are talking about, what worries me, frankly, is that, on the one hand we have in the back of our heads that we could do this with a public program better, and the other side, we look at the costs and that creates a stalemate and we do nothing.

Then we are missing the opportunity, it seems to me, to encourage greater private savings for the long-term care risk, and I think that should not be lost sight of. It is a very important piece of these deliberations.

Mr. CHANDLER. I very much agree. My concern, Mr. Chairman, is that there may not, in terms of economic reality, be one bit of difference between reducing the amount we are collecting now, thereby increasing peoples disposable income, and then having this huge liability occur around 2010, and what we are doing today. I say this because we are spending money in the Social Security trust fund on current obligations. I do not think the money is there, and will not be there when we need it.

Chairman STARK. Mr. Gregg.

Mr. GREGG. Thank you.

Mr. Meyer, do you have a number for how much your reinsurance plan would cost? It is set at $100,000.

Mr. MEYER. Pardon me?

Mr. GREGG. It is set at $100,000.

Mr. MEYER. Yes. I really do not know what it would cost to set it at $100,000. I am sorry. Frankly, I do not think these are the kind of proposals that I have seen costed out by CBO, or other model builders, and I wish I had a number to tell you what that kind of back-end coverage would cost.

But I just do not know where—I tried to find it, but I cannot find it.

Mr. GREGG. Have you got a guess?

Mr. MEYER. My guess is that you could have a pretty good stop loss or reinsurance provision for something on the order of magnitude of four or $5 billion a year in annual expenditures, as opposed to, say, $20 to $30 billion a year costs that might——

Mr. GREGG. Let's say we applied your stop-loss reinsurance to the acute-care catastrophic function, plus the long-term care function. Would the figure still be in the four to five billion range, or would that increase it considerably?

Mr. MEYER. Well, it would depend on whether you coupled that with the premium increase suggested by Secretary Bowen.

That is, as I understand it, the new part of the part A and part B protection, at the back end, would be internally financed by premium——

Mr. GREGG. Well, no, what I am thinking of is that if you used the money that we are going to use on the acute-care catastrophic——

Mr. MEYER. Right.

Mr. GREGG [continuing]. Instead of using it purely on acute-care catastrophic, if you spread it over a stopgap, stop loss, or a reinsurance plan for both acute care and long-term care——

Mr. MEYER. Right.

Mr. GREGG [continuing]. Whether the money comes from the Stark-Gradison plan, or whether it comes from the Bowen plan, would the money now being used to finance acute-care catastrophic be enough to finance a combined stop loss on acute care and with long-term care?

Mr. MEYER. I would seriously doubt it because the proportion of Medicare patients that run over the 60-day hospital stay, and so on, is so very small.

Now I know they also envision in that plan covering expenditures over $2,000. I do not know for sure, but my guess is the answer is no. That the unmet needs on long-term care, even at the back end, are significantly great, that they would not be financed just by moving it over.

I guess what I had in mind was doing something partial. Maybe it would be to raise that $2,000 figure of Secretary Bowen to $5,000, or even $10,000, or, to a level that would enable you to carry it laterally over into——

Mr. GREGG. That is what I am talking about.

Mr. MEYER. Yes.

Mr. GREGG. At what level do you get to that figure?

Mr. MEYER. I do not know. I honestly do not know. That is the kind of thing I would like, to see costed out. I do not have the data to do it.

I do not know where the "break-even" point is, how high you would have to raise the stop loss under part A in order to do that.

Mr. GREGG. Do you have any way of getting those numbers? We have a lot of trouble getting numbers.

Mr. MEYER. Yes. I know. I am a private researcher, and I cannot put any demands on public organizations whether it is HHS or CBO, but I will certainly make the inquiries, and if I find out, I will let you know immediately.

Mr. GREGG. It would be very helpful.

I think the idea is very attractive. You take care of the poor, as you say, by bringing Medicaid into the insurance obligation. It makes a lot of sense to me to try to get more for our dollars.

Mr. MEYER. Right.

Mr. GREGG [continuing]. In the area of coverage. So if you could come up with some numbers it would be a great service to at least one member of this committee.

Mr. MEYER. I will try.

Mr. GREGG. Thank you.

Mr. WIENER. While I find the idea very attractive in principle, I guess I am not certain you can come up with a uniform number that would apply for both acute care and long-term care.

Most of the acute-care people remain in the community, and you have to leave people enough money to pay for their room and board, and living expenses, so I think you should probably have a lower catastrophic limit for that population.

If you are in the nursing home, your basic room and board costs are essentially being paid for through the facility. Moreover, at $1,500 to $2,000 a month in a nursing home, basically you are saying that at $2,000, that everyone who spends more than a month in a nursing home has reached that catastrophic level and you are therefore talking about 90 percent of all nursing home admissions.

Mr. GREGG. Well, I do not mean to interrupt, but I do not think anybody is suggesting uniform numbers. I think you are talking two different plans, two different stop-loss levels.

The question is, how much do you have to raise the $2,000 stop-loss figure? Do you have to raise it to $5,000, or $10,000 to raise the money necessary to support $100,000 on long term?

Mr. WIENER. Right.

Mr. GREGG. Thank you.

Chairman STARK. Mr. Daub.

Mr. DAUB. I have just a comment. I think that the direction in which we ought to go is a public/private partnership, and I do think that there is a necessity for a part C because it is an affordability issue as well, and probably a question of what the numbers are going to look like in 10 or 15 years.

We do not know what the complexity of that aging population's health-care costs may be. So I do think we should be careful about what we do.

But we do need to prepare for the changing demographics in 1995. That is why I offered a bill, hoping that there is a window of opportunity here. My colleagues are aware of this opportunity and my colleague, Mr. Donnelly and I, offer three ideas.

One is a very carefully defined, straight-line income-related approach based upon the idea of $10,000 to $15,000 of stop loss on long-term nursing home care. We add to this approach a private sector quid pro quo—a tradeoff—and that is that you need to have some incentive for people who are now 50 years old, and older, to start to save, to provide for that long-term private sector opportunity for health care.

There are some private long-term care policies being offered now. The companies offering these policies are venturing forth, using survey research that has been done, to see if they can, for $900 to $1,200, offer a very generous long-term 400-day, 1-year, 2-year, 3-year life-care-type policy. These are not $2,000 and $3,000 policies.

These policies could wrap around medigap and supplemental insurance as well, and become super-supplementals.

But it is very, very important, I think, that we do not wait till 1995 to try to figure out what we are going to do in this area. There is a large group of 60-year-old people who are alive, who are worrying about their retirement, and who have mothers and fathers who are 90 years old who spent their resources to pay for health and long-term care.

We are fostering this spend-down phenomenon by ignoring where the true catastrophic cost is. It is on the long-term care side. It is not on the acute side, given the SSI, Medicaid, Medicare part A, Medicare part B, and what we are now paying for in the transferring of wealth, or readjusting, or apportioning of who pays for what.

So we offer an opportunity, that is, an interest exclusion, if you put that interest up to $1,500 on a premium for long-term care with a cash benefit or defined benefit.

And we offer a group opportunity like we did under Kerr, so that over 10 or 20 years we will start to build a stream, where, as Mr. Stark said, maybe 50 percent of America will not need to worry about what Government takes care of because at age 65 and 75, and 85, they were okay, they thought, but now they have got to spend down before they can get quality health care.

But I really found your dialog with the committee and its good attendance for your input today to us, very stimulating, and I am glad I was here. I am glad you were here, too.

Mr. Chairman, thank you.

Chairman **Stark**. I just have one more question of Mr. Meyer.

You raised the figures, I think, or you mentioned that half of the SSI potential population does not qualify.

Mr. **Meyer**. Do not participate.

Chairman **Stark**. Do not participate.

Mr. **Meyer**. Yes.

Chairman **Stark**. Now as I read that, we are now spending $10 billion and change on the ones who do.

Are you suggesting that if we had a really perfect outreach program we would have a $10 billion, sort of liability hanging over our heads there, that is kind of a contingent liability?

Mr. **Meyer**. Well, in theory you do, but I do not think in reality it is that way. I mean, I think there are at least three reasons why that half the poor—and I might add almost half the disabled potentially eligible do not participate.

One is ignorance. They do not know of the program. Two is the welfare stigma. And three may be that benefits are not worth it, they are so low for some of them.

I think therefore if you raise benefits—and our study shows this—if you raise benefits a little, that in itself would increase participation, and we have presented some figures on that.

I am troubled by what you raise, because, you know, the question is almost a moral one.

Does the Government have an obligation to go out into the hinterlands and tell folks that they are eligible for something, knowing that if it does it is going to cost money.

Frankly, I think the Government——

Chairman **Stark**. We do that in the draft.

Mr. **Meyer**. Pardon?

Chairman **Stark**. We did it in the draft.

Mr. **Meyer**. Yes, that is right. And I think if we can do it on the obligation side, the obligation of people to their Government, we can do it on the obligation of Government to their people.

I do not think sending a notice out in a Social Security check once every few years is enough.

I do not think you have to go to every door, but I think that in between we could make an effort to find those people who are not participating because of ignorance, or because they do not have a ride down to the office, as opposed to those who do not want to, and yes, it would cost more money.

I do not think you would ever have a doubling of it, but the cost would go up.

Chairman STARK. I guess my next question, though, is this: Let's say it would go up $3 to $5 billion, and it is something we could do without busting the budget because it is there.

How would you trade off that expenditure of three to five as opposed to other things we might do to target that same population?

Would that be your top priority, or would you say expand the Medicaid buy-in, or——

Mr. MEYER. Well, I frankly would start with the Medicaid buy-in, because I think the most important vulnerability that low-income people have is not to the $340 a month cash assistance, but to the possibility of being vulnerable to tens of thousands in health care expenses.

So I guess if I had to prioritize, and that is what you are asking me to do, I would start by leaving SSI for a moment where it is, just relax the asset test, and begin to do what the Congress permitted to be done, both in AFDC and SSI, which is cover those who are poor but not in the welfare programs.

I think that would be step one. Step 2 would probably involve the asset test relaxation, and then we could begin to think about potential benefits and outreach. And I know that you have to set priorities.

Chairman STARK. Mr. Moody.

Mr. MOODY. Thank you. Let me just quickly ask a couple of questions on the financing side which interests me the most.

Do each of you agree, that whatever we do in this area should be generationally neutral, or do you think we should come up with a financing device or scheme which transfers a lot of resources between generations?

Mr. WIENER. I would say that whatever program you come up with is going to have to draw significant amounts of money from every generation.

Certainly any public program would need to have significant premiums paid for by the elderly as well as substantial sums by the working population.

I think it is a key point to try to get the baby boom population putting money aside in either a public or private program to pay for their own long-term care needs which will come out in the future.

Mr. MOODY. Well, can I read your answer to say yes, it should be generationally neutral, and that the taking of money from each generation by various devices, and over various periods of time, should be for their own retirement?

In other words, the baby boom generation should start saving now, compulsorily, or however?

Or are you saying the baby boom generation now should pay for long-term care retirees now?

Mr. **Wiener**. Well, I think——

Mr. **Moody**. Should we impound the money and hold it for them, or should we spend it now like we are doing with Social Security?

Mr. **Wiener**. Well, I think the answer is a mix. We want to start building up reserves so that the baby boom population can pay for itself later on down the road, but I do not think we should say that only people who are 30 years of age now will ever get a public program.

I think we have serious needs now and will have to pay for the short term, largely out of the current working population.

Mr. **Moody**. So you do support another transfer?

Mr. **Wiener**. Excuse me?

Mr. **Moody**. You do support a transfer between generations on this, then, for now?

Mr. **Wiener**. I do not see any other way to finance the current elderly population.

Mr. **Moody**. Okay. Any other responses? Yes, sir.

Mr. **Meiners**. One of the difficulties with long-term care is that it is more than the medical care. It gets very much into the social services.

This is one of the reasons why it is difficult to ensure the risk either publicly or privately. It is part of the reason why I have been emphasizing the importance of encouraging people to put aside resources. Are an important part of what long-term care is, is just paying for a longer lifetime, putting aside resources to pay for the kinds of support services that are necessary as we grow old.

And so, from that standpoint, I think a significant amount of it has to be something we do for ourselves.

Mr. **Moody**. Generation by generation.

Mr. **Meiners**. That is right.

Mr. **Moody**. Mr. Meyer.

Mr. **Meyer**. Well, I think it should be generationally equitable. I do not think that means neutral in a dollar for dollar sense because, after all, if we are protecting our parents now, it is helping us.

If we did not protect them, we would have to pay for them more privately. So I do not think we should just sock the money away for ourselves, as it were.

Mr. **Moody**. But should I pay for someone else's parents?

Mr. **Meyer**. Yes, I think we should help pay for someone else's parents, particularly if they are very poor.

I think that one of the things I tried to do in my testimony is mention a series of options, some of which hit up, frankly, the relatively well-to-do senior citizens, and some of which tax the relatively better off non-senior citizens.

I think if we are going to tax social insurance benefits more, it is also equitable to tax employee benefits more. We have a lot of untaxed fringe benefits. Taxing more of these benefits, of course, is a controversial proposal, but I think in fairness to today's senior citizens, it would not hurt for my employer's contribution to my health insurance, over some margin, to be taxed, and to use that money to put away for those of my cohorts who are unlucky enough to have long-term care needs.

Mr. **Moody**. Do you like the actuarial value taxation feature of the Stark-Gradison proposal, I assume?

Mr. **Meyer**. Yes.

Mr. **Moody**. Do others of you agree with that?

[No response.]

Mr. **Moody**. Let me ask you a general question. Should Medicare benefits, be they long-term or catastrophic, be in some sense included in taxable income so that in fact you may be generationally neutral but you are not neutral with respect to income class, and those who have more pay more?

Mr. **Wiener**. Medicare benefits?

Mr. **Moody**. Yes.

Mr. **Meyer**. I think they should, with this proviso which I believe is in the Stark-Gradison bill. That you would not tax the beneficiary on the money he or she spends, either during his working years, or the part B premium.

That is to say, you would not tax 50 percent of part A that represents the employee's share put in all his life, and you would not tax 25 percent of part B that represents his premium contributions very roughly, but I think it is fair to tax that person on the other parts put in by his employer and by the government.

Mr. **Moody**. Excuse me. Just to interrupt. You are taxing the pay inside rather than taxing the actuarial value of the benefits side, right? That is how you would approach it?

Mr. **Meyer**. Well, you could do it either way. I believe that CBO has estimated a revenue take of about $14 billion over 5 years from doing it the way I suggested.

Mr. **Wiener**. I would only make the point that over the long haul, while we surely will need to raise more taxes from upper-income elderly, the fact of the matter is that there are not that many of them, and we are going to have to reach into the working population and raise taxes there as well.

Mr. **Moody**. All right. My last, very brief question is: given that fact, and stressing upper income, underlining the word income, do the three of you think that assets should be substantially figured into the calculation when we talk about the burden?

Or do you think we should only look at incomes? You know, the obvious bipolar example is a widow sitting on IBM stock that has almost no income associated with it, but has a lot of capital growth, versus someone who has no assets but a slightly higher income. Clearly the first person has a much higher capacity to share the burden than the latter.

Mr. **Meyer**. Well, ideally, I agree with you, sir, but the problem is data and information. I mean, we know people's income from their 1040 form, or whatever they file on their taxes. It is pretty hard to know what their assets are, to know what to tax.

I mean, you are right, but it is difficult to do.

Mr. **Wiener**. I would agree with Jack, but I would also add the proviso, that while there is a proportion of elderly that has a significant number of assets, I do not think we should overstate that as well.

Especially, once again, talking about the long-term care population, that population does not have, outside of the house, major assets.

Mr. Moody. I would just respond, and say that taxpayer morale, and equity may put assets into the equation even though it does not raise a lot of money. I will ask the third gentleman, and then I will give up my time.

Mr. Meiners. One of the reasons that we think there is an interest in private financing options, is to protect assets. So part of what we are trying to encourage people to do is to dig into their assets, to deplete them gradually so that they can be assured of having a nest egg to pass along because they have protected themselves against this particular risk.

The other thing to note is that one of the concerns associated with the need for long-term care has been people transferring assets to gain Medicaid eligibility. While we can take issue with the morality of such practices there really have not been many other options for people. The emergence of private financing mechanisms is helpful in this regard because it gives consumers options.

And now, as we begin to see private options, some of that concern may dissipate. At least we can work on trying to—if we are going to think in terms of interventions there, at least people are beginning to have some options.

They did not before. And so I think those things are——

Mr. Moody. Thank you very much, all three of you. Thank you, Mr. Chairman.

Chairman Stark. Mr. Levin.

Mr. Levin. I have no questions, Mr. Chairman. Thank you.

Chairman Stark. It is the Chair's intention to work through, and we will begin voting on the floor about 1 o'clock. There may be a journal vote around noon. And if I will not offend any of the witnesses—it would let everybody get to their own future appointments—we will make a little bit of a change in the next panel composition.

But I want to thank this panel very much for their testimony and their work. I appreciate it. Thank you all.

I am going to ask the second and third panel to come to the witness table together and we will just save us a little time as we move along.

James Firman, who is president and chief executive officer of United Seniors Health Cooperative. Mr. Kenneth Scholen, the director of the National Center for Home Equity Conversion.

And then, if Mr. Firman and Mr. Scholen will start at what will be their left end of the witness table, and if they are accompanied by anyone, if the people accompanying them would just take a seat behind them it would help. We will let everybody get in.

And then Paul Willging who is executive vice president of the American Healthcare Association, John Rother who is the director, division of legislation, research and public policy for the AARP, and Kay Hollers, who is chair of the government affairs committee of the National Association of Home Care.

I appreciate your letting me improvise in this way. I assure you that once that voting starts after the debate on the veto override, we have a series of six or eight votes behind that, and I am afraid you would be here all day if you wanted to get your testimony into the record.

Why do not the two members of the second panel proceed to summarize their written testimony, or expand on it if they wish, and with the understanding that their complete testimony will appear in the record in its entirety.

Mr. Firman.

## STATEMENT OF JAMES FIRMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, UNITED SENIORS HEALTH COOPERATIVE, WASHINGTON, DC

Mr. **Firman**. Thank you, gentlemen.

I am pleased to be here to be able to address you on this important issue to our country and to millions of older Americans.

United Seniors is a self-help organization of older people in the greater Washington area. Our mission is to enable older people to gain access to high quality and affordable health and long-term care.

With support from the Commonwealth Fund, United Seniors has been working to develop new financial option to enable older people to finance long-term care and to maintain independent living.

For the record, I would like to submit a background document that summarizes the state-of-the-art in the field of home equity conversion, and the second is an analysis of State options for financing home equity. I think they will be useful to you and staff and other people interested in the field.

The major issue that I would like to address today, the core issue, is access to the credit markets. Younger people and working people are dependent on credit to finance their life style. Without credit, younger people would not be homeowners, they would not have credit cards, and they would not have the economic choices that they currently have. Yet, when people retire, they are effectively barred from the credit market.

The home equity lines and the home equity loans that we hear so much about are simply not available to most retirees because they will not be able to repay their loan out of future earnings.

Older people are being discriminated against. They cannot borrow, despite having perfectly good assets. In other words, our financial institutions are prepared to make a loan of $100,000 to buy a house to a 25-year old who has minimum equity and a job that may or may not continue in the future. Yet, we are not prepared to make a loan of $50,000 or $60,000 for home care services to an 85-year old with $100,000 in growing equity and a life that may end soon.

Lack of access to the credit market is annoying for most older people, but becomes a major personal and societal problem when catastrophic illness or long-term care needs emerge. We estimate that there are 2.25 million older homeowners currently who need help to maintain independent living. Yet, most of the current initiatives, including Secretary Bowen's plan, other initiatives that I am aware of on the Hill, and the Brookings studies—initiatives that look at improving long-term care financing do not really address the need for more home care. Older people prefer home care. If they had adequate access to the credit markets, it is clear that many would borrow to remain at home.

Improved access to the credit market could lead to as much as doubling of funds available to pay for home care in this country.

While we are debating the long-term solution, which may or may not happen 20 years from now or 10 years from now, the least we can do is make it possible for older people to maintain themselves at home now.

I am just going to summarize two of the conclusions from our work under the commonwealth study grant, and my colleague, Ken Scholen, will address others.

First, it is clear from our surveys and research of older people that they greatly prefer a flexible disbursement or line of credit option to any sort of fixed payment home equity program.

Second, the three most important features of these home equity plans from the consumers' perspective are guaranteed lifetime tenancy, flexible disbursement, and adequate consumer counseling and protection.

The current situation is analogous to the housing finance situation after World War II. Then we had millions of people with significant potential earning power who wanted to buy homes, and Congress had the foresight to encourage FHA and VA insurance which enabled secondary markets to develop and for these people to become homeowners.

Today, many from the same generation of people need to borrow money to stay at home. Despite strong collateral, they are denied credit.

Reverse mortgage insurance can serve the same function that FHA and VA insurance served 40 years ago. Think about it. Public policy, in the late 1940's and early 1950's encourage people to invest in their homes. Now we need to enable them to use those assets to their best advantage.

Mark Meiners pointed out just a few minutes ago that we need to encourage people to invest more in assets. Well, as a matter of public policy, we did. We told an entire generation of people to invest their assets in their home, they did and now they are stuck. I think we have a responsibility to help them get unstuck.

Over the past 8 years, most of the true leadership in this field has come from the private sector, as exemplified by people like Ken Scholen and Bronwyn Belling, Bruce Jocobs, Jim Burke and innovators at the State level, particularly in Connecticut, Rhode Island and Virginia.

With all due respect, their leadership has not been matched by the Congress. I think it is time for Congress to get off the dime and to take actions that can open up the credit market for older people. Older people should have equal access to the credit markets as a matter of basic economic and civil rights.

Improving access to the credit markets will not in itself solve the long-term care financing problem, but it can help up to two million people pay for the help they need to stay at home.

Thank you.

[The following was subsequently received:]

# The State-of-the-Art in Home Equity Conversion

Presented to the Subcommittee on Health, Committee on Ways and Means

by

United Seniors Health Cooperative*

Most older Americans never derive any cash income from their single largest financial investment. Most older Americans own a mortgage-free home, and live in it until they die. Because they do not sell and move, they never turn this frozen resource into cash.

Converting home equity into income while living in one's home is the purpose of various "home equity conversion" (HEC) mechanisms now being developed and tested in different areas.

This statement presents the current state-of-the-art in home equity conversion. First, it discusses the several types of HEC plans now in operation. Then it examines experience to date with the most flexible type of HEC plan: the "reverse mortgage". This leads to an exploration of potential improvements in the reverse mortgage instrument. The statement concludes with a look at the future market potential for home equity conversion.

## I) Home Equity Conversion (HEC) Plans

There are two basic methods of converting home equity into income: borrowing and selling. HEC loan and sale plans differ from conventional forms of borrowing and selling in important ways, however.

To qualify for a traditional home loan, a borrower must have income sufficient to make regular (usually monthly) payments. With a HEC loan, the borrower does not need a regular income source because there are no payments. Indeed, the borrower takes out the loan to create a regular income, and makes no repayment of any kind until a future time.

In traditional home sales, the seller vacates the premises and the new owner takes possession of the property. In a HEC sale, the seller remains living in the home while receiving proceeds from the sale.

This section discusses three types of HEC loan plans (reverse mortgage, reverse mortgage with shared appreciation, and special purpose loans) and two types of HEC sale plans (sale leaseback and split equity).

A) HEC Loan Plans - The three basic types of loan plans are 1) reverse mortgages, 2) reverse mortgages with shared appreciation, and 3) special purpose loans. Both types of reverse mortgages have been offered primarily in the private sector, whereas special purpose loans have been offered exclusively ~~in~~ the public and non-profit sectors.

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* Prepared under a grant from The Commonwealth Fund by Maurice Weinrobe (Clark University, Worcester, MA) and Ken Scholen (National Center for Home Equity Conversion, Madison, WI)

1) reverse mortgage (RM) - In its simplest form, the reverse mortgage works like a common mortgage loan, only "in reverse." The common mortgage starts with a large, lump sum advance from a lender to a borrower, who uses the funds to buy or refinance a house. The loan is secured by the property. Over time, the borrower repays the large loan on a monthly installment basis until all principal and interest have been repaid.

In a reverse mortgage, the borrower already owns a house. The lender makes loan advances to the borrower on a monthly installment basis. Over time, the loan balance grows as principal and interest accumulate. The loan is ultimately repaid in a large lump sum when the borrower dies, moves, or at a time agreed upon at the beginning of the loan.

RMs have been offered by public and nonprofit agencies, as well as by private institutions. The public offerings of RMs have included programs by state (CT and RI) and local (Musashino) governments. Banks and S&L's have offered RMs in Arizona, California, Connecticut, Massachusetts, Minnesota, New Jersey, New York, Ohio, Pennsylvania, and Wisconsin.

The basic RM is a term instrument with scheduled payments or disbursements to the borrower. Interest is added to the loan balance each month. As time elapses, the size of the loan balance grows at an increasing rate because of the accumulation of interest. The size of payments or disbursements on a term RM is a function of the interest rate, loan term, and the target loan balance at maturity.

The relationship of the disbursement to the loan parameters can best be understood using an example. Under one RM plan, the target loan balance is limited to 75% of appraised value. For example, if a property was appraised at $60,000, the borrower could take out a RM with a loan balance at maturity of as much as $45,000. The monthly disbursements to the borrower would depend on the term of the loan (i.e., how many monthly disbursements would be received) and the interest rate.

Clearly, the longer the term (the more disbursements to be received) the smaller the monthly disbursements would be. If the agreed upon term was seven years, and the interest rate 12%, the monthly disbursement would be approximately $341. If the term was 10 years, the disbursement would be $194.

The monthly disbursement and compounded interest will accumulate to the target loan balance at the term of the loan. The monthly payment to the borrower is much more sensitive to the length of the loan than it is to the interest rate. On an $80,000 home, for example, a change of two percentage points in the interest rate never changes the disbursement by more than $45. But a two-year difference in the loan term can change the monthly disbursement by as much as $279.

The basic RM is a term loan. That means it is due on a certain date, and (with a fixed interest rate) that is why the loan balance is predictable. Of equal importance, a fixed term offers a substantial amount of certainty to the lender. If the loan will be repaid by a certain date, and if the loan balance is constrained within that time period, the lending institution can control its risk exposure. This is the basis for the loan-to-value ratio used by the lender: 75% in our example. Additionally, the fixed term means that it is unnecessary for the lender to vary disbursements by age of borrower, sex, or marital status.

The other side of a fixed-term loan is that a borrower may in fact want to remain in her or his home at the maturity of the loan. If the borrower desires to remain, some action must be taken on the loan: it might be paid back (either in total or on an amortized basis by switching it to a forward mortgage); or it might be put into an interest accruing status (with the borrower paying currently accrued interest or with the interest being added to the loan balance); or it might be allowed to continue as before maturity (either with the same monthly disbursements or with a different disbursement schedule). The existence of such contingencies at the end of term is generally viewed negatively by lenders; they are the major disincentive for lenders to offer term RMs.

Some term RMs have a built-in provision that can take care of some of the contingencies or uncertain outcomes. If property appreciation has occurred during the term of the RM, the loan can be extended or "rolled over" in accordance with the increase in property value. This does not fully protect the homeowner or achieve perfect certainty of the term outcome, but it does at least provide some protection if there is appreciation. (It is difficult to incorporate such contingencies into loan documents as lending regulations often require that the maximum loan balance be identified and that specific maximums not be exceeded.)

The specification of action to be taken if sufficient appreciation occurs is an important obligation. In fact, property appreciation over five to ten year time periods has been the general rule in most areas of the U.S. during the post-World War II period. Property values fluctuate from year to year, but when viewed over ten year periods the pattern of sustained appreciation is consistent in all regions of the country. While this is true in general, it is also true that each individual transaction would be viewed by a lender as being subject to appreciation risk.

The practical result of this situation has been to limit the RM to specialized circumstances that are well suited to a fixed-term instrument. These have included persons needing monthly income supplements for a transition period - until a buyer can be found for the home, until an opening becomes available in a congregate living facility. RM disbursements have also been used to pay for in-home services for seriously (in some cases, terminally) ill persons. Borrowers of advanced old age (80 and older) have selected RM loan terms that exceed their life expectancies.

Because the fixed-term RM has limited applicability, the costs of consumer information and education have been high. In most instances, they have been shared by non-profit or public agencies that provide information and counseling to prospective borrowers. On the other hand, RMs are inherently flexible and adaptable instruments, with substantial potential for developing or enhancing a lender's relationship with its customers.

2) RM with shared appreciation - The Century Plan™ (CP) is the first long-term, open-ended reverse mortgage being operated on a for-profit basis. (A small-scale, non-profit plan has made a few loans in one California community.) The CP was developed and is being marketed in five states (NJ, MD, OH, PA, CT) by American Homestead, Inc. of Mount Laurel, NJ.

The CP loan is paid out to the borrower in monthly cash advances. The borrower receives these advances until she or he dies, moves, or reaches age 100 -- whichever comes first. In the case of borrowers who live to age 100 and wish to remain in their homes, the loan agreement provides for an automatic rollover of the loan, and continuing advancesuntil any new maturity date they choose. Thus, in effect, the CP provides a guarantee of income as long as the borrower retains the home as a principal residence. In essence, the borrower is not obligated to make any loan repayments until she or he dies or moves.

Interest is charged on the monthly advances and added to the loan balance. The interest rate is fixed during the loan term. The borrower agrees to pay "additional interest" at the end of the term equal to some percentage of any appreciation in the home's value during the term of the loan. The percentage of appreciation to be paid to the lender is agreed upon between borrower and lender at loan origination and is an important factor in the determination of the monthly payment. The greater the appreciation share promised the lender, the higher the monthly advance.

Other factors that influence the amount of the monthly advance are the borrower's age, the fixed rate of interest, the number of borrowers (that is, sole or joint ownership), the portion of the home's value that is not pledged against the loan, and the home's value. Monthly advances are fixed throughout the loan term; they do not increase or decrease.

At the end of the loan term, the borrower's total liability is limited to 94% of home value, or the fraction of the value pledged against the loan. The total amount of additional interest that the lender may earn is also limited by a "hyper-inflation" clause. Any appreciation in excess of what would result from an annual average value increase of 15% is excluded from the additional interest calculation.

The cost of the CP to the borrower depends on the loan options chosen, how long the borrower remains living in the home, and how much the home increases in value. Persons who remain in their homes a short time or whose homes increase substantially in value pay relatively more for the loan advances. On the other hand, those who remain in their homes a long time or whose homes increase little in value will pay less.

The effective combined interest rate on the CP (i.e., the fixed interest charged on the loan advances plus the appreciation share expressed as a single rate) is sensitive to tenure in the home and appreciation. For example, a 70-year-old borrower with a $70,000 home who elects to pay all future appreciation receives $271 per month. If her home appreciates at 10% per year and she dies or moves three years later, the effective annual interest rate on her loan is 73%. If, on the other hand, her home appreciates at 5% per year and she lives until age 94, the effective annual rate is 7%. This interest rate volatility is an inherent feature of appreciation-sharing RMs that can be modified by instrument design.

The fixed interest rate under the CP is intended to reflect market conditions and to be set at a level below market mortgage rates. In fact, the rate was set at 11.5% when the plan began operations (early 1984) and has remained at that level. Monthly disbursements have also remained the same.

The two most important distinctions between the CP and a term RM are the guarantee of income as long as the owner (or at least one of the owners) is an occupant in the home, and the uncertain loan balance. The loan advances continue as long as the owner retains the home as a principal residence, but after a permanent moveout the advances stop and the loan balance becomes due.

3) special purpose loans - A number of public and nonprofit loan programs have been established to help older homeowners meet specific types of needs. Typically, these "special purpose loans" do not have to be repaid until the borrower dies or sells the home. But all loan proceeds must be used for a specified purpose.

The most frequently used HEC instrument is property tax deferral. In 17 states, older homeowners can get a loan from their state or local government to pay their property taxes. The loan is secured by a lien on the home, and usually carries an interest rate of 6% or 8%. But the loan balance need not be repaid until the borrower dies or sells the home.

Another type of public program that is based on home equity is the deferred payment loan (DPL) for property repairs and improvements. DPLs have been used by many housing and community development agencies to upgrade the quality of homes owned by older persons. These loans can also be effectively combined with private sector RMs. This lowers the combined RM-DPL interest cost for borrowers, and improves the security of the loan for lenders. DPL programs are usually targeted to specific geographic areas and income groups.

In the Tokyo suburb of Musashino, a public sector RM loan program tied to the provision of in-home health care and other services has been operating for several years. This plan also provides loan advances for discretionary income purposes as well. In America, the potential use of home equity for financing long-term care has been explored recently in studies by the Minnesota Housing Finance Agency and the Connecticut Governor's Commission on Long Term Care Financing.

B) HEC Sale Plans - The two basic types of HEC sale plans are 1) sale leasebacks and 2) split equities. The former is ordinarily a private sector instrument, whereas the latter has been used by public and nonprofit agencies.

1) sale leaseback - A sale leaseback is a financial arrangement widely used by businesses, especially large corporations. A number of tax considerations make a sale leaseback attractive to both parties to the transaction. Sale leasebacks used for HEC purposes are similar in structure to commercial transactions.

The elderly homeowner sells the home to an investor. The investor may or may not be a related party, such as a son or daughter. The investor agrees to rent the house back to the elderly seller with a long lease - perhaps the agreement would be for the seller's lifetime. Through either a seller carryback of a note, or purchase of an annuity, the seller receives a monthly income flow from the transaction. As long as the monthly income is well in excess of the rent payments, the seller receives a net cash income and is able to remain in the home.

It is customary for major maintenance, property taxes, some insurance, and perhaps other property expenses to become the responsibility of the investor. These reduced homeowner expenses are, in effect, income to the seller. In addition to these agreed upon financial flows, there are tax aspects of the transaction that serve to enhance the attractiveness to investors. However, recent federal tax reform reduced the value of the depreciation and other deductions that undergird the transaction.

Residential sale leasebacks for the elderly can be drawn up by knowledgeable real estate attorneys on a custom basis . Because any two parties can arrange their own terms, there is no need for sale leasebacks to be offered by a special kind of business or HEC program. Because they are complicated, though, and because it may be easier to have standard agreement forms, it is reasonable to expect that HEC programs or businesses would offer this type of instrument.

Documented experience with residential sale leasebacks to date has been extremely modest. Six commercial ventures have offered a sale leaseback, or the instruments with which to do a transaction once the parties to the deal have found one another. Three of these efforts are no longer in operation. Estimates of the volume of each venture have not been made available to the public, but it appears that together they have completed less than 100 transactions.

2) split equity - Split equity transactions have been the focus of a public program in Buffalo - the Home Equity Living Plan (HELP). Under this arrangement a nonprofit entity purchases a remainder interest in the house of an elderly homeowner. The homeowner is entitled to remain in the home for life and is relieved of major maintenance expenses, property taxes, and some insurance. The program provides any initially necessary rehabilitation work. The homeowner also receives either a one-time lump sum cash payment, or an annuity for life. At the death or moveout of the homeowner, the program can sell the home and, with the infusion of funds, make a new purchase.

A split equity transaction like that of the HELP program requires a fund of capital with which to begin and operate the program. Once the fund is in hand, the generosity of the terms of the program will affect its appeal to potential participants. The Buffalo program operated actively from late 1981 through 1984. Its capitalization came from an allocation of a community development block grant to the City of Buffalo. Ultimately, as a consequence of actions of the U.S. Department of HUD, the program was required to close off new transaction. During the period of activity, the Buffalo program completed approximately 65 transactions.

The average value of homes in the HELP program was between $20,000 and $25,000 - wll below the naional average. When given the choice between a lump sum cash settlement and an equivalent life annuity, homeowners opted almost exclusively for the lump sum.

## II) Reverse Mortgage Experience to Date

The HEC experience has not been voluminous, but it has been instructive. This section reviews RM experience-to-date by examining A) the demand for RMs, B) the supply of RMs, and C) marketing RMs.

A) RM demand Demand has been lower than expected, and much lower than some expected. The total quantity of fixed term RMs originated by the major nonprofit HEC programs since 1981 has been in the neighborhood of 500. The shared appreciation RMs of American Homestead, Inc., have reached approximately the same number of transactions in a shorter period of time: approximately 500 in three years. In both cases, the quantity of loans closed was smaller than the plan organizers expected.

There seems to be little question that part of the explanation for the small number of RM transactions lies in the novelty of the instrument, and the time required for the entire aging network or society to become familiar with them. But there are also some specific reasons for demand to develop slowly, and for the demand to be low for the specific instruments that have been marketed. (In England, it has taken 15 years for reverse mortgages to gain public acceptance. Most of the approximately 17,000 mortgages currently outstanding were written since 1981, when significant tax advantages were enacted.)

It is commonplace for providers of RMs to remark that "they are not for everyone," but they have not always been marketed with that in mind. Particularly with a fixed-term RM, it is necessary to match the instrument with the individual circumstances of the borrower. Older homeowners do not represent a homogeneous group, and the term RM should not be expected to appeal to all homeowners, or even all homeowners who fit the expression, "house rich and cash poor."

One factor of overriding importance is that elderly homeowners as a group do not like debt against their property. Nowhere is this more evident than with tax deferral programs. In spite of the fact that these types of loans generally have a low to moderate interest rate and are not due until sale or death, the use of such deferrals has been low in relation to the eligible population (in no state has the participation rate exceeded 6%). Elderly homeowners are reluctant to accept debt.

If this debt carries with it the risk, even a minimal risk, of a possible forced moveout, or the possibility that the owner's estate will be seriously diminished by the existence of the debt, or the possibility that when circumstances really get bad there will be nothing left on which to borrow, the number of homeowners still willing to consider a RM becomes even smaller.

We do know that RMs appeal more to some homeowners than others. The greatest appeal seems to be to the single female with substantial equity and low income, who is 75 years of age or older. It does not seem to matter very much whether the house is large or small, or whether the owner has lived in the home for a long period of time. It also appears the decision to take out a term RM is often precipitated by some event, such as an illness or the illness of a spouse, perhaps along with the need for housing rehabilitation or maintenance. Put differently, term RMs do not seem to be especially important for general income supplementation, but rather tend to be used only when absolutely necessary.

B) RM supply - Private RMs have been funded either by lenders or by private funds raised by lenders. Banks and savings and loans have originated RMs using their own funds. American Homestead has funded its CP either from capital or private borrowings. By comparison with forward mortgages, there has been no resale of RMs and no secondary market has developed. The dependence on originators' own funds has discouraged the active participation of financial institutions.

Financial intermediaries try to control, if not eliminate, risk. They do this in many ways, but for our purposes a major way is through the sale of the long term loans they originate. If a loan can be sold, the financial institution can retain the servicing responsibility of the loan, receive servicing fees, and face no risks. By comparison, the risks associated with a term RM are substantial.

The major uncertainty of a term RM from the lender's perspective is that a homeowner may remain in the home to maturity, not want to sell or move, and that the property will not have appreciated. In this set of circumstances the lender would either have to force a sale and move by demanding payment on the note or allow the homeowner to remain in the home even though the home is insufficient collateral on the note (that continues to grow in size with accumulating interest).

Other risks faced by the lender are dependent on the way the RM is structured. If the interest rate is fixed, there is interest rate risk. Because the loans generally have no prepayment penalty, the actual repayment date is uncertain. The fact that banks and other financial institutions do not generally make loans to the elderly, and rarely make loans on a basis other than prospective income and credit, makes RM loans unknown quantities. It is customary to talk about borrowers being frightened by RMs because of their novelty, but in fact the same should be said of lenders.

A related issue is why there is no secondary market for RMs. Here the explanations really come down to two: potential investors in the secondary market are sensitive to the same risks as originators; and, before a secondary market can develop there must be a much larger volume of loans - and loans that can be packaged. The only way a secondary market could exist at today's volume of originations would be without a serious intent on the part of the purchaser to make a profit.

C) RM marketing - The successful HEC programs have been those that can get their message out in a clear and nonthreatening way that HEC represents a reasonable and reliable way of generating a cash flow, with specific risks that can be clearly identified. The biggest discouragement to HEC is uncertainty -- both uncertainty of the future and the consequences for the loan, and uncertainty of what is happening with the instrument. To the extent that the major uncertainties that concern the homeowner can be confronted and resolved, the promise of completing HEC transactions is enhanced.

One way that has proven important to reduce uncertainty is independent counseling. The existence of a counseling source can be important, if it is independent, readily available, and knowledgeable. These three factors are hard to meet in every instance. The only way a counselor can be an effective intermediary between borrower and lender is if there is an independent relationship to both parties, but independence by itself does not impart confidence. The advice of the counselor must be consistent and accurate, and it must be easily available to the homeowner and to family and other advisors.

A related matter is that of advertising and information channels. The lenders or originators of RMs must get their own message out if there is to be any volume of transactions. In addition to traditional private sector marketing activities (ads in various media), it is important to generate an awareness of the product among social service providers, and those who are likely to be in a position to advise elderly homeowners who are likely candidates for HEC. Hospital discharge planners and medical social workers are important vehicles of information.

## III) Potential RM Improvements

The major problems with existing RMs are the risks associated with term instruments, the lack of a secondary market, and the limited number and types of instruments. None of these are insurmountable problems.

The risk of a term instrument is that a homeowner will survive the term to maturity of the loan, want to remain in the house, and that the house will have experienced little appreciation. This represents a combination of events, and the likelihood of all things occurring to the same homeowner is small, but the costs of such an occurrence to a single lender could be large. Like so many risks, the easiest way to confront the risk is to pool it. For every homeowner who experiences all of the negative risk factors, there are many more who do not experience them (all in combination). If those who do not become problem cases could contribute in some way to cover those few who do, the losses associated with the few could be covered by the many.

The easiest way to cover term RM risk is through some kind of risk pool or insurance. A lender with a large volume of loans might be able to self-insure through the establishment of a reserve fund. A private (or probably more likely) a public entity could offer insurance against RM term risk. Premiums might or might not be charged, there could be complete or partial coverage, and there could be copayments and deductibles.

A reverse mortgage insurance mechanism has been proposed on a demonstration basis in legislation now before the Congress. This particular plan (H.R. 1020) represents the current consensus and state-of-the-art in RM insurance design.

The lack of a secondary market could be resolved without addressing the term problem, but it might also be resolved by eliminating the term problem. As already indicated, the development of a secondary market is inhibited by scale problems and by the term problem. If the term problem were removed, some larger financial institutions (public and private) might be willing to purchase RMs with the expectation that secondary market development would lead to a longer run buildup in volume.

Lastly, the evolution of instrument design has been interesting, but the state of the art in HEC instruments is still primitive. In the future, instruments could be developed that eliminate interest rate risk, that allow the borrower greater discretion in the amount of income drawn, and that combine the proceeds of the instrument with a specific use (e.g., long-term care insurance).

One of the more limiting aspects of RMs currently available is that they essentially require a fixed disbursement schedule. Not all potential borrowers have a need for a steady and level flow of income. Many homeowners want to be able to meet expenses as they arise, or to have the ability to meet unforeseen expenses. The Virginia Housing Development Authority (VHDA) is currently working on such an instrument. With technical assistance provided by United Seniors Health Cooperative through a grant from The Commonwealth Fund, VHDA is designing a line of credit program that meets the special needs and circumstances of older homeowners.

The early development of RMs has been in the direction of generic instruments designed to appeal to a broad class of borrowers. The secondary development has been towards specialization - either specialization of marketing or specialized custom features of the instruments. The specialization of instruments and features will allow much more to be done with HEC instruments, and RMs in particular, in the near future. The emergenceof new insurance products to safeguard borrowers and lenders will be an important and necessary part of this development process.

Chairman Stark. Thank you.

Mr. Scholen.

## STATEMENT OF KENNETH SCHOLEN, EXECUTIVE DIRECTOR, NATIONAL CENTER FOR HOME EQUITY CONVERSION, MADISON, WI

Mr. Scholen. Thank you, Mr. Chairman.

I appreciate the opportunity to be with you this morning. Let me begin with a word of caution and a fairly substantial grain of salt.

Reverse mortgages are still in a very early, uncertain and fluid state of development. They have produced by far the fewest transactions, only about a thousand nationwide, of any home equity conversion instrument. But they are the most flexible of the various plans and best suited to financing long-term care in a variety of ways.

If a viable reverse mortgage market is to develop in this country, there will need to be significant progress in three areas. First, independent consumer information and counseling are needed to help homeowners understand and make informed decisions about the various options.

Second, a wider range of more flexible and adaptable instruments is needed to respond to the variety of financial needs among the elderly.

And, third, lenders and borrowers alike need a generally available method for pooling the risk that some borrowers might otherwise outlive their equity.

Important developments are now beginning to occur in each of these three areas.

First, the American Association of Retired Persons has recently established a Home Equity Information Center within its Consumer Affairs Department.

Second, State governments are designing innovative products. For example, Virginia's Housing Development Authority is developing a flexible line of credit reverse mortgage with deferred repayment. This instrument would permit equity conversion on a lump sum or intermittent basis. It would allow financing of accessibility improvements and other modifications in the home that help older persons remain in their homes.

It could finance a wide array of in-home support services, durable medical equipment and other devices that promote independence.

Because of the changing nature of home care needs over time, this very adaptable instrument would offer clear financing advantages over other types of reverse mortages.

The third major current development is the consensus that has emerged on the design of an FHA reverse mortgage insurance demonstration proposal. With an insured reverse mortage, homeowners could convert equity while deferring repayment until death or voluntary sale of the home. Lenders would be repaid from the proceeds of the estate or sale and, if necessary, and within statutory limits, from a risk pool funded by premiums on each mortgage.

Early returns from reverse mortgage programs suggest that anywhere from 15 to 65 percent of borrowers use the proceeds for long-term care purposes.

In England, where reverse mortgages are well established now, help with the various tasks of daily living is purchase by one-fourth to one-half of the borrowers.

What are the prospects for reverse mortgage financing of long-term care in America? They depend most fundamentally on whether or not a viable reverse mortgage marketplace in fact becomes established in this country. It is not there remotely yet. And that establishment in turn depends primarily on the development of reverse mortgage insurance. But because current and near-term demand for reverse mortgages is so low, private reverse mortgage insurance is very unlikely to appear much before the turn of the century.

On the other hand, an FHA reverse mortgage insurance demonstration has immediate potential for, first, safeguarding pioneering consumers and lenders who take risks early on in the development of the market; second, encouraging program growth and design innovation; third, supporting consumer awareness and understanding of these various instruments; fourth, demonstrating the viability and workings of reverse mortgage risk pooling; and fifth, hastening the day when sound reverse mortgages provide secure opportunities for more older Americans.

Thank you.

[The prepared statement follows:]

Testimony

presented to

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
March 31, 1987

by

Ken Scholen, Executive Director
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Madison, Wisconsin

## Introduction

There are several basic types of financial instruments that convert home equity into income: property tax deferral programs, deferred payment loan programs, sale leaseback plans.

But the most promising home equity conversion (HEC) plan for financing long term care (LTC) is the reverse mortgage (RM). This instrument has produced the fewest transactions to date of any HEC instrument. It is also at a much earlier, more uncertain, and more fluid state of development than any of the other types of plans. But it is the most flexible, and best suited for financing LTC in various ways.

## Reverse Mortgages (RMs)

In its simplest form, the RM provides a series of monthly loan advances to a borrower, with repayment of all principal and interest deferred until a future time. How long the borrower gets the monthly advances and when the loan must be repaid are the key factors that differentiate the basic types of RMs that have been offered to date (see attached statement, pp. 2-3).

If a viable RM market is to develop in this country, there will need to be significant progress in three areas:

1) Consumer Support - Independent consumer information and counseling are needed to help homeowners understand and make informed decisions about home equity conversion options.

2) Design Innovation - A wider range of more flexible and adaptable instruments is needed to respond to the variety of financial needs among the elderly.

3) Risk-Pooling - Lenders and borrowers alike need a generally available method for pooling the risk that some borrowers might otherwise outlive their equity.

## Current RM Developments

The good news is that important developments are beginning to occur in each of these areas:

1) Consumer Support - The American Association of Retired Persons (AARP) has recently established a Home Equity Information Center within its Consumer Affairs Department. The Center has already produced several excellent publications on HEC for lenders, attorneys, and financial planners. A comprehensive consumers guide is currently being developed. The Center has also created a system for providing up-to-date, state-specific information on HEC programs nationwide. Finally, AARP's Consumer Housing Information Services program is being activated in selected states where HEC plans are being offered.

2) Design Innovation - State governments have begun to provide leadership in designing reverse mortgage (RM) products that respond to a broader range of consumer needs. Connecticut's Housing Finance Agency is offering a unique plan that guarantees monthly payments for ten years, but defers repayment until death or sale of the home. Payments may continue beyond the ten-year guarantee period depending on the amount of the advances and the rate of home appreciation during the guarantee period. This plan is offered in conjunction with the Connecticut Department on Aging, which provides consumer information and counseling on all available HEC programs. The Rhode Island Housing Finance Agency has developed a similar program that offers ten, fifteen, and twenty-year guarantee periods.

The most promising current state development is underway in Virginia. With technical assistance supported by The Commonwealth Fund, Virginia's Housing Development Authority is developing a flexible line-of-credit RM. This instrument would enable older homeowners to draw down equity on a lump sum and/or intermittent basis.

It would permit, for example, the financing of accessibility improvements and other modifications that accomodate a home to the changing physical capabilities of older persons. It could finance the purchase or rental of durable medical equipment and other devices that provide in-home support. It would also allow homeowners to withdraw equity regularly, but on other than a fixed monthly basis. Because of the changing nature of in-home support needs over time, this instrument would offer clear advantages for home care financing.

3) Risk-Pooling - Considerable progress has been made over the past four years in the development of an FHA reverse mortgage insurance demonstration proposal. Through this program, a limited number of insured RMs would be written by authorized lenders.

These mortgages would enable older homeowners to convert their equity into income while deferring their repayment obligation until death or voluntary sale of the home. The lender would be repaid from the proceeds of the estate or sale and - if necessary, and within statutory limits - from a risk-pool funded by premiums on each mortgage. This demonstration program would provide the first insurance mechanism specifically designed for safeguarding borrowers and lenders in RM transactions.

## LTC Financing?

Preliminary and informal returns from the handful of RM programs currently in operation suggest that anywhere from 15% to 65% of RM borrowers use the proceeds for LTC purposes. Although it is too early to draw definitive conclusions, it appears that the variation in LTC use among programs may depend on factors such as the age of the program (with LTC use increasing over time), the basic orientation of the program (with counseling and awareness of LTC needs and resources being associated with greater LTC use), the instrument(s) offered, and certain demongraphic variables (home values, age of borrowers, LTC costs and needs).

In England, where RMs are now well established, help with the various tasks of daily living was cited as a reason for borrowing by one-fourth to one-half of RM borrowers.

What are the future prospects for RM financing of LTC in America? They depend most fundamentally on whether or not a viable RM marketplace becomes established in this country. And that, in turn, depends primarily on the development of RM insurance and risk-pooling. Because current and near-term demand for RMs is so low, however, private RM insurance is unlikely to appear much before the turn of the century.

On the other hand, an FHA RM insurance demonstration has immediate potential for safeguarding pioneering consumers and lenders, encouraging design innovation and program growth, supporting consumer awareness and understanding, demonstrating the viability of RM risk-pooling, and hastening the day when sound RMs provide secure opportunities for more older Americans.

Statement

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by

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National Center for Home Equity Conversion
Madison, Wisconsin

What role can home equity play in financing long term care (LTC)? At what stage of development are the home equity conversion instruments most suited to LTC financing? And who is asking these questions?

Let me address them in reverse order: A) issue context, B) instrument development, and C) potential LTC financing roles.

## A) Issue Context

The issue of home equity financing of LTC has been raised by at least three groups: consumers, developers, and policy analysts.

Consumers have used the proceeds of home equity conversion (HEC) plans (principally reverse mortgages) to buy LTC services. Purchasing help with the tasks of daily living has been a significant use of reverse mortgage advances in England and America. Research at the University of Michigan has found that the percent of older persons deeming it appropriate to borrow for health care purposes is twice the percent deeming it appropriate to borrow for everyday living expenses. On the other hand, the risk of future LTC costs may be a factor that prevents some consumers from entering a HEC plan.

Developers of HEC plans have sought in various ways to orient their programs to LTC financing needs. The original plan for Buffalo's Home Equity Living Program included an array of in-home services. That idea is now being revived in current proposals for a "life care at home" programs with optional home equity financing. As the San Francisco Development Fund's RAM program found that a substantial number of its clients were using their new income to purchase LTC, the program re-oriented its outreach efforts to LTC providers and intermediaries. In a suburb of Tokyo, a municipal HEC plan is directly tied to LTC needs.

Policy analysts have only recently begun to explore the potential for home equity financing of LTC. Jacobs and Weissert have documented that the homeowners with the greatest need for LTC (single persons aged 75+) are also the homeowners with the greatest capacity for HEC. Their analysis has also quantified the objective potential of home equity for financing LTC insurance and services. A study-in-progress at the Brookings Institution models various means of financing LTC with home equity.

Within the past 15 months, state governments have begun to analyze their policy options in this area. Minnesota and Connecticut commissioned studies of state roles in home equity financing of LTC. Wisconsin's Secretary of Health and Social Services proposed an "incentives for LTC insurance" initiative based on the Minnesota study. A national research project on older persons living alone - funded by The Commonwealth Fund - is developing reverse mortgage variations better suited to LTC financing in conjunction with state housing finance agencies.

## B) Instrument Development

Financial instruments for converting home equity into income are still in a very early stage of development. Property tax deferral programs are currently available in 17 states, but participation rates are very low. Deferred payment loans for home repairs and improvements have been offered by a variety of public and nonprofit agencies. Consumer demand for these programs has usually been strong. Sale leaseback plans, on the other hand, have had difficulty attracting investors, and federal tax reform may compound the difficulty.

The HEC instrument that has recorded the fewest transactions to date - the reverse mortgage (RM) - is also the most flexible plan, and has had the most varied development history. Over the past five years, three basic types of RM instruments have emerged, and new variations are currently being developed.

The three RM prototypes to date are the term RM, the HFA-RM, and the IRMA. The main differences among them involve the loan advance term, the repayment term, and the interest charges (see chart below).

The term RM offers monthly loan advances for a fixed term of years (usually ten or less) with repayment of all principal and interest due when the term of advances ceases. The RM offered by two state housing finance agencies (HFA-RM) provides monthly advances for a fixed term, but defers repayment until the borrower dies or sells the home. The "Individual Reverse Mortgage Account (IRMA)" makes monthly advances for as long as the borrower lives in the home. All three plans charge a fixed rate of interest on the loan advances. The IRMA plan also charges a share of future appreciation in the home's value.

| | Term RM | HFA-RM | IRMA |
|---|---|---|---|
| Monthly Loan Advances Are Guarantied | For a fixed term of years | For a fixed term of years | Until borrower dies or sells home |
| Repayment of Loan Balance Is Due | When loan advances cease | When borrower dies or sells home | When borrower dies or sells home |
| Interest Charged Is | Fixed rate on loan advances | Fixed rate on loan advances | Fixed rate on loan advances plus shared appreciation |

The term RM is available throughout Connecticut, most parts of California, and in one or two areas of Arizona, Massachusetts, Minnesota, New Jersey, New York, and Wisconsin. Approximately 400 of these loans have been written since 1982. With few exceptions, lenders have offered this instrument only in conjunction with nonprofit or public sector counseling programs that understand its inherent risks and limitations, and carefully screen applicants accordingly.

The single largest term RM program reports that approximately 25% of all its clients - and over one-half of current clients - use their monthly advances to pay for in-home care and support services. The FHA RM insurance proposal currently before the Congress would reduce the risks and limitations of this instrument for borrowers and lenders alike.

The HFA-RM has been available for the past year and a half in Connecticut, and for the past several months in Rhode Island. Approximately 100 of these loans have been written. Housing finance agencies in other states are currently exploring the development of similar programs. A research and technical assistance project funded by The Commonwealth Fund is providing consultation services to these agencies. The project, operated by United Seniors Health Cooperative (D.C.), is also developing a flexiblw line-of-credit instrument that is more suited to financing variable LTC costs.

Various factors suggest that HFAs may provide fertile ground for RM development. They are not subject to the loan velocity and corporate profitability pressures of private sector instruments. Their public or quasi-public standing reduces or eliminates certain regulatory and licensing barriers. It also gives them greater capacity for cooperative marketing efforts with other government and nonprofit agencies.

HFAs are likely beneficiaries of the proposed FHA RM insurance program. HFAs and private lenders would be eligible for this insurance. But HFAs may have more motivation and be better situated to use it.

The IRMA is available in Connecticut, Maryland, New Jersey, Ohio, and Pennsylvania. Approximately 500 of these loans have been written since 1984. The IRMA plan was developed by American Homestead Mortgage Corporation of Mount Laurel, NJ.

Although IRMA loans written to date are fully funded, the ongoing viability of American Homestead is uncertain. An inadvertent result of federal and state banking legislation in recent years has been that the IRMA plan cannot be offered at this time in the very state (New York) that could make American Homestead a viable business entity. Corrective legislation first introduced in 1986 at the request of Governor Cuomo is currently being considered by the New York Legislature.

The future of RM lending is likely to follow one of two paths. If more HFAs become involved in RM lending, if the FHA insurance proposal is enacted, if the New York legislation passes soon, then we can expect a slow but steady growth in the availability of RMs. If these events do not take place, then it is possible that RM lending would die out for a time, and perhaps re-emerge in the future as demographic and generational factors become more favorable.

## C) Potential Roles

Publicity about the development of HEC plans is responsible for much of the current interest in home equity financing of LTC. It does not therefore follow, however, that HEC instruments are the only or the best means of involving home equity in the financing of LTC.

Certainly HEC plans can play a direct role in LTC financing. RM proceeds are currently being used to pay for LTC services. A flexible line-of-credit arrangement (with repayment deferred until death or prior sale of the home) would be even better suited to LTC financing needs. But present barriers to supply and demand (including in particular the lack of RM insurance) mean that these direct types of HEC financing are not likely to play a major role in LTC financing within the immediate future.

A different type of role that home equity could play in LTC finance is more indirect, but it could also have more potential for substantial impact. The indirect role relates to the treatment of the home equity asset by the Medicaid program. Medicaid policy can either encourage or discourage the involvement of home equity in financing LTC. It can also influence or determine the type of involvement, e.g., risk-pooling or fee-for-service.

If Medicaid incentives discourage the involvement of home equity and allow it only on a fee-for-service basis, then the potential of home equity financing cannot be fully realized. On the other hand, if Medicaid incentives encourage the involvement of home equity, and if they do so on a risk-pooling basis, then more of the considerable objective potential could be realized.

| | Fee-for-Service | Risk-Pooling |
|---|---|---|
| Direct Financing Role (HEC) | 1) RMs for LTC Services<br>2) DPLs for LTC Expenses | 3) RMs for LTC Insurance<br>4) Home-Paid Life Care at Home |
| Indirect Financing Role (Medicaid) | 5) Forced Home Sales<br>Liens on Homes<br>Estate Recoveries | 6) Incentives for LTC Insurance<br>7) Pre-Paid Medicaid |

This chart displays seven ways in which home equity can play a role in financing LTC. These seven roles are arranged according to whether they involve direct financing (through HEC plans) or indirect financing (through Medicaid treatment of home equity); and according to whether they finance LTC on a fee-for-service or risk- pooling basis.

1) RMs for LTC Services - Consumers are already using RM income to purchase LTC services. The further growth of RM lending could lead to more of this activity, particularly as more flexible and secure RMs are developed. A line-of-credit instrument, FHA insurance, and greater coordination between RM and nursing home preadmission screening programs would increase the use of RMs for financing LTC services.

2) DPLs for LTC Expenses - Some state and local agencies have provided lump sum, zero-interest loans for home repairs and improvements that do not have to be repaid until the borrower dies or sells the home. These deferred payment loans (DPLs) can generally be used for property modifications that enhance accessibility or accomodate the changing physical capabilities of elderly residents. They have not usually been available, however, for the purchase of durable medical equipment or other devices that provide in-home support. Program changes to allow a broader range of uses, and greater coordination of DPLs with preadmission screening would increase the use of this instrument for LTC purposes.

3) RMs for LTC Insurance - RMs could also be used to purchase LTC insurance. For the immediate future this is not likely to be more than an occasional occurence, however. Consumer demand for both products is very low, and the availabilty of both products is still quite limited.

In the future, if both products gain consumer acceptance, it is conceivable that RM advances could be used to pay LTC insurance premiums. In particular, persons who begin paying premiums out of pocket in their fifties or sixties might switch to RM advances in their seventies or eighties. It is also possible to develop an integrated product that provides cash advances plus LTC insurance coverage. To some degree, offsetting risks would produce a more efficient combined product.

4) Home-Paid Life Care at Home - A handful of development efforts currently underway envision the provision of all the services of a continuing care retirement community (CCRC) to persons living in their own homes. One possible financing option for these managed care arrangements is the use of home equity sale or loan instruments. In addition to CCRC services, the package could include housing services such as maintenance, repairs, and upkeep.

5) Forced Home Sales, Liens, and Estate Recoveries - The most important outcomes of the current Medicaid policy on home equity are to encourage persons to remove their home equity from any involvement in LTC financing, and to recover as much home equity as possible from those who do not preemtively transfer or shelter it.

A critical deficiency in this policy is that it permits home equity to play only a fee-for-service role in the public LTC financing system. Forced home sales, liens, and estate recoveries extract repayment for services already provided. They do not pool risk; they simply bill the afflicted who have played by the rules.

The amount of home equity involved in preemptive transfers and other Medicaid shelters is not known. But even the most aggressive recovery efforts have produced scant results. A program cited in a HCFA study as "the most successful in the nation" recovers only 1.7% of Medicaid costs.

6) Incentives for LTC Insurance - This policy proposal reverses current home equity incentives and allows home equity to play a risk-pooling role in the Medicaid program. In particular, it provides a a public sector incentive for consumers to purchase private LTC insurance.

Under this approach, persons holding approved LTC insurance policies would be able to receive Medicaid LTC benefits without ever being forced to sell their homes, without being subject to liens and estate recoveries, and without having to spend-down some portion of the liquid assets required by current regulations.

The degree to which LTC insurance would reduce the need for Medicaid would depend on the coverages in the approved LTC insurance policy. The incentives offered by Medicaid would depend on their cost in relation to the savings from lower Medicaid use.

This approach would support and promote the development of private LTC insurance. Providers would benefit from more risk-aware consumers, less Medicaid competition, an enhanced product, and a larger risk pool.

Consumers would be given a new choice beyond the "nursing home roulette v. pre-emptive asset shelter" alternatives currently available. Private LTC insurance would include a public element of home equity preservation and asset protection. Any increases in the number of policies offered and sold would also make improved coverage and/or lower premium charges more likely.

There are potential drawbacks to such a policy, however. What begins as an incentive for those able to purchase LTC insurance can become a de facto penalty for those who cannot. Moreover, an incentive program predicated on rewarding individual decision-making loses much of its rationale if LTC insurance is purchased primarily on a group basis. Finally, the ongoing balancing of public costs and benefits would require monitoring and program adjustments. And it is possible that future changes in the LTC insurance market might undercut the public purposes of an incentives program.

A report last year by the Minnesota Housing Finance Agency contained the first extended discussion of Medicaid incentives. At present, the Wisconsin Department of Health and Social Services is exploring a variety of issues relating to this concept.

7) Pre-Paid Medicaid - An alternative to the "Incentives for LTC Insurance" proposal would enable consumers to purchase public sector LTC coverage on a pre-paid, risk-pooling basis. Policyholders would be entitled to a defined range of LTC services without qualifying on a means-tested basis. Already the LTC insurer of last resort, the government would now collect explicit premiums from persons wanting to guarantee future coverage without having to spend-down income or assets, and without having to transfer assets.

Home equity financing could play an important role in any public sector brand of LTC insurance. If consumers were allowed to purchase eligibility through debt or cash, out-of-pocket premium costs could be reduced or eliminated for many.

An integrated HEC/LTC insurance program in the public sector would have two important economic advantages over separate HEC and LTC programs in the private sector. The profit margins of both the lender and the insurer would be eliminated. Moreoevr, the risks of a long-term HEC instrument could be offset to some degree by the countervailing risks of LTC insurance. Separate private sector programs could not achieve these efficiencies. Mispricing risk and other "infant industry" problems would remain, however.

Chairman **Stark**. Thank you. Mr. Scholen, you are familiar with the demonstration project in the housing bill?

Mr. **Scholen**. Yes, I am.

Chairman **Stark**. Does that insofar as it is outlined generally touch on all the areas that you think——

Mr. **Scholen**. The version that was originally in H.R. 4 is not the consensus proposal. I know of no one who supports that particular version. It is not based on a workable insurance concept, and the consumer safeguards are inadequate.

There is another version—H.R. 1020—submitted by Representative Wortley that is virtually identical with two minor variations—and they are inadvertent ones—to a proposal in the Senate housing bill. H.R. 1020 is the consensus proposal that people in this field support.

Chairman **Stark**. Just two other questions. Is there any reason that right now we have to make any specialized tax provisions? It would seem to me there is one, rather than get the $125,000 out in a lump sum to let them more or less take it out over time. As you know, we allow in the Tax Code $125,000 of equity to be taken out once free of tax, but that has to be done on the sale of a home.

I suppose there is a tax change that would be needed to give that same benefit, the equivalent benefit to somebody who annuitizes the value. But I do not know that has been a roadblock up until now. Okay, you are saying it has not.

The third question, what would you think of tying this reverse equity to some kind of specific long-term care benefit? In other words, right now for SSI and Medicaid, we disregard the equity in a home for qualification. That may or may not be fair. I mean, if you spend down all your other assets, you may not have enough money to pay the taxes. So that may be not as effective as needed.

But on the other hand, possibly this could be required from people who could afford it as a condition of additional benefits, not as a condition of present Medicaid benefits. But if we were to create some more generous long-term care, how do you think that would be received?

In other words, the government would have a lien, if you will, on the equity at the end of the life of tenants?

Mr. **Scholen**. Medicaid long-term care benefits are virtually open-ended. It is difficult to see how they could be made significantly more generous. State Medicaid programs already have the ability to place liens on homes, to force the sale of homes, and to file claims against estates.

As alternative approach—which is discussed in my written statement—would be to provide home equity conserving incentives within the Medicaid program to encourage homeowners to purchase long-term care insurance. This voluntary program would make insurance a better buy for consumers while decreasing the likelihood they could need Medicaid. Another alternative discussed in the statement is a pre-paid Medicaid plan that enables homeowners to use their home equity to purchase Medicaid coverage without means-testing. Because they involve risk-pooling, either of these voluntary approaches is likely to be more efficient and productive than any new program of liens, forced home sales, or estate recoveries.

Mr. **Firman**. Mr. Chairman, I think there is an interim more politically palatable position: a voluntary program by States with reverse mortgage insurance to make the option available to people who need long-term care.

Chairman **Stark**. It is a program that I would like; it is unfortunately not within our province of this committee to do. Would you both agree that the most important thing is to get some kind of an insurance program to protect the lenders, and that unfortunately—not unfortunately, but that is not under the jurisdiction of this committee. I think that steps are being made, and we are just looking for whether there is a tax handle on that or an asset consideration that we ought to think about. But it is mentioned often as a source of financing long-term care, and as I say, we would share some jurisdiction there, if the resources were dedicated.

Maybe you would do an extra deduction early on when you begin to acquire the home, and you have got an extra deduction if, in fact, some of that equity is pledged prospectively for long-term care.

Mr. Levin.

Mr. **Levin**. I think we need to go on, but I just want to express that I agree with the thrust of your questions.

It seems to me as we expand the system there has to be a heavier emphasis on equity. There is no way to increasingly meet long-term care without a greater premium on the equity of burden. I think that is what you are saying in your proposal.

It was yesterday we were told this is not the place, but I think everybody should confront the gist of the chairman's question.

My hunch is this is just the first crack at this. We are going to be spending more and more time on the issue of comprehensive long-term care, and I hope very much we can. I think everybody needs to face up to issues of how we spread the cost and should not increasingly burden, affect ability. I personally think without carrying it too far the answer is clearly yes.

So your kind of reaction when the chairman referred to taking into account that asset some way or another is government is the public host to provide care. I think that is not off the wall by any means. It is closer to on the mark than it is off the wall.

Mr. **Firman**. I think it is analogous to the authority the States have to seize the home as an asset for Medicaid admissions. It may be one thing for the Congress to allow it; it may be another thing for the States to implement the program.

Mr. **Levin**. And I might add, Mr. Chairman, I think the thrust of it is even increased by the changes in the estate tax.

Chairman **Stark**. Yes.

Mr. **Levin**. Thank you.

Chairman **Stark**. Thank you. I will excuse the first two witnesses and recess for about 5 minutes. I am anticipating that in the next 5 minutes there will be a vote. We may run to 8 minutes. So if the remaining panel would not mind waiting just a few minutes, we will get a little business out of the way and get back here.

[Recess.]

Chairman **Stark**. We will continue, the first person on our concluding panel is Paul Willging. If you would like to proceed, Dr. Willging, in any manner that you are comfortable.

## STATEMENT OF PAUL R. WILLGING, PH.D., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. WILLGING. Thank you, Mr. Chairman. It is a pleasure to be able to discuss with you today the issues related to——

Chairman STARK. If I could interrupt for just a minute. I wanted to pass along for the benefit of my minority members that Dr. Bowen is meeting with the minority group at lunch, and that accounts for the absence of the minority side. My majority colleagues are just late.

Mr. WILLGING. It is a pleasure, Mr. Chairman, to be able to speak with you today.

I have submitted written testimony which contains most of the specific points I would like to make. But the needed improvements in the Medicare statutorily defined goals, if made, they would be insufficient to deal with the issue of long-term care.

I have heard a lot of discussion today about the incremental approach to trying to restructure the current programs, Medicare primarily, in terms of the jurisdiction of this committee.

I think it is important, Mr. Chairman, that as one looks at fine-tuning the Medicare program—and I will focus primarily on the SNF benefit, which is of greatest concern to me—we have to also look at the degree to which, given the current management of that SNF program, simple expansions of the benefit, for example, as you and Congressman Gradison have suggested from 100 to 150 days will not come close to meeting the needs of the eligibles as long as the Health Care Financing Administration continues through its own approaches to truncate those same benefits.

Let me use just one example. It is in area of coverage. You and Congressman Gradison in your proposed legislation have suggested an expansion of the SNF benefit from 100 to 150 days. I would suggest that if that proposal is enacted, it will, indeed, not add one day to the SNF benefit as long as the Health Care Financing Administration, through its arcane processes referred to as coverage determination, continues to limit the average paid-for benefit under Medicare to 29 days.

I am not at all sure how those coverage decisions are made. I suspect it has something to do with reading the entrails of goats, ducks and doves, but I do know that HCFA has been very effective both in denying to the beneficiaries the rights to which they are entitled, and making it all but impossible for providers to participate in the Medicare program.

I would suspect that the Congress must go beyond simply dealing with the length of the benefit. Congress must also deal with the issues of cost reporting, the cost reimbursement system, and the coverage determination process itself.

But let me go beyond the current programs and suggest that even with modifications, we cannot continue to rely on existing programs to deal with the catastrophic health care needs of America's elderly. Indeed, it is frustrating for me and, I am sure, others in this town to listen to the President when he submitted his program to the Congress for dealing with catastrophic health care expenses and suggest he is "thereby providing the last full measure of security for America's elderly." He is, indeed, only providing 10 percent of that last full measure of security because 10 percent is what acute care accounts for in terms of catastrophic health care expenses.

I would here simply quote your colleague, Mr. Daub, who suggests that "Congress cannot claim victory on the issue of catastrophic health care expense if it fails to address the long-term health care needs of the elderly."

Why is it, then, that we are not doing so? Why is it that we continue to have a fixation with the tip of the iceberg, rather than with the seven-eighths of the problem lying beneath the surface? We have heard sufficient testimony today as to why that fixation: it is because of the issue of cost.

Yet I would like here again to repeat the testimony of Josh Weiner who suggests the issue is not whether we can afford to pay for long-term care services for the elderly because we are, in fact, paying for long-term care services for the elderly, to a total of some $40 billion per year. The issue is not whether we pay because we are paying; the issue is, rather, how we choose to allocate, to distribute, to apportion those costs.

I think, Mr. Chairman, we must recognize that the chronic long-term care problem is there, and it needs to be dealt with. By delay we will simply find it that much more difficult a problem; we need to sit down today and sort out a financing mechanism that meets the needs of the American public, of the Congress, and the beneficiaries. I have heard at least one today which I think warrants some further discussion and deliberation. Mr. Meyer has referred to it as the "stop-loss" approach. If the Congress feels there is a role with respect to the Medicare program but is concerned—as indeed it should be—with the cost implications of that role, then there are methods whereby the Federal role could be limited to those outrageous extremes in terms of the need for long-term care. Greater incentives would accrue to the beneficiary to cover the interim, 1, 2, 2½ years, whatever it may be.

I would suggest the one advantage that was not raised by Mr. Meyer in terms of his stop-loss proposal was that it provides an incredible incentive both to insurers and beneficiaries to cover that intervening period. Through private insurance the insurers would for the first time have a very clearly defined benefit they need to provide as a product to the beneficiary. The beneficiaries would have a much more easily controlled benefit that they need to purchase.

I think this is the kind of discussion needed to engage in, Mr. Chairman. We must recognize the problem is there, and it needs to be dealt with. Let us talk about how to finance it.

Thank you very much.

[The prepared statement follows:]

# LONG-TERM HEALTH CARE COVERAGE FOR THE ELDERLY

by

Paul R. Willging, Ph.D, Executive Vice-President

of the

THE AMERICAN HEALTH CARE ASSOCIATION

The American Health Care Association is pleased to have this opportunity to provide comments on catastrophic medical expenses. As the largest association of long term care providers responsible for the care of approximatly 900,000 nursing home patients every day, AHCA is all too familiar with the elderly's needs for financial protection from catastrophic health care expenses. Dr. Paul Willging, executive vice president of this association was pleased to serve on Secretary Bowen's Public-Private Sector Advisory Committee on Catastrophic Illness. This type of commitment toward a broad based, collaborative effort is needed to satisfactorily address the issue of financing the catastrophic health care costs facing our nation's elderly.

AHCA recognizes and appreciates the diversity of opinion that has come to the Committee's attention as a result of these hearings. Public discussion will be essential if we are to resolve the problem. While the diversity of opinion does not make the task of the Committee any easier, we applaud your efforts to provide a forum for those who will be affected by the results of your deliberations.

More than any other type of provider, long term care providers are directly involved in delivering services on a daily basis to those with catastrophic illness. Providers recognize that nursing home residents are faced with a substantial financial burden that current proposals on catastrophic coverage do not address. We also recognize that current budgetary constraints may limit your ability to develop a legislative package that includes long term care coverage. Nevertheless, we welcome the opportunity to bring issues related to long-term care financing out of the closet and into the policy arena. The effort will require a commitment much like that needed to enact tax reform proposals last year. Congress has demonstrated its willingness and ability to confront such challanges. AHCA will support your efforts to develop catastrophic legislation by providing input at every available opportunity.

Medicare changes contained in the major catastrophic health care proposals being considered on Capitol Hill would affect less than three percent of the nursing home population. This Congress must begin to address the increasing numbers of the elderly who require nursing home care. AHCA supports two options for dealing with the problem of long term care financing.

We believe serious consideration should be given to a system of private long term care insurance that is mandated as part of employer fringe benefit packages. Premium financing would be shared by employers and employees. Under such a plan, private insurance would replace most of the long term care benefits under Medicaid. Low wage earners could have a proportion of their premiums subsidized by Medicaid and non-wage earners would receive full subsidization for their premiums.

A second option would be to design a modest Medicare long term care benefit to be supplemented by private insurance, personal resources, and a much reduced Medicaid program for the very poor. Under this approach, Medicare would provide catastrophic coverage only after a long deductible period, perhaps as long as two years. This extended deductible period would serve as an incentive for individuals to purchase private, supplemental long term care insurance. This option has elements in common with H.R. 1776, The Long Term Healthcare Amendments of 1987, introduced on March 25, 1987 by Mr. Daub and Mr. Donnelly.

Whatever is accepted as a solution to dealing with the long term care component of beneficiary needs, private insurance will ultimately play a major role. However, insurance will have little immediate impact unless federal incentives are developed to stimulate the market. AHCA supports tax credits to individuals and employers for the purchase of long term care insurance as well as accelerated write-off of research expenses related to product development.

Given the committee's jurisdiction, we will focus our remaining comments on aspects of the catastrophic proposals which, from the perspective of the Medicare beneficiary, could go far to facilitate access to skilled nursing care when acute hospital care is neither medically indicated nor cost-effective. We are firmly committed, however, to a comprehensive approach that involves the health programs and private sector initiatives.

Current restrictions in Medicare coverage for skilled nursing services render the benefit inadequate for protecting the elderly from financial burdens associated with nursing home care. These restrictions also obstruct skilled nursing facility access even when the use of a SNF for post-hospital care is indicated and within the scope of benefits intended by Congress. Action must be taken to eliminate these restrictions and reassure Medicare beneficiaries that claims to "free the elderly from the fear of catastrophic illness" are more than just hollow political promises.

AHCA applauds the recognition of the excessive patient cost-sharing associated with the existing SNF benefit. The current rate of $65.00 a day from day 21 through day 100, is so high it exceeds the private pay rate in many facilities. In fact, because of the high cost-sharing requirements, the Medicare SNF benefit effectively ceases after 20 days. Furthermore, the cost-sharing amount is also illogical because it is calculated on the basis of the inpatient hospital deductible. On this point, AHCA urges support for either the provision of H.R. 1245, The Medicare Catastrophic Illness Coverage Act, that repeals the coinsurance requirement for post-hospital extended care or, alternatively, H.R. 1280, The Medicare Part A and Part B Catastrophic Protection Act which requires a coinsurance set at 20 percent of the national average per diem cost for SNF care only for the first seven days of care.

Equitable cost-sharing, if applied, should be applied to all Medicare benefits in a manner that is consistent and logically related to the services provided. Patient cost-sharing should not be so burdensome as to render the benefits totally illusory as is the case with the current SNF benefit.

AHCA also supports the elimination of the "spell of illness" concept as proposed by the Administration in H.R. 1245. Spell of illness should no longer apply for purposes of determining eligibility under Medicare. The concept is ambiguous as drafted and arbitrary as applied. The amount of Department resources applied in the past to unsuccessfully litigating this issue could have been better spent on direct beneficiary needs. The provision contained in H.R. 1280 which caps the annual benefit at 150 days will provide a meaningful post-hospitalization benefit for Medicare recipients.

AHCA is in favor of establishing a reasonable upper limit for out-of-pocket expenses under Medicare. This change will assist the elderly in better structuring their personal resources to meet the anticipated expenditure. In keeping with the underlying premesis of our association, to provide better access to the Medicare beneficiary, we believe this limit should be set at the minimum level possible to recognize the fact that for many seniors, even $2000 in out-of-pocket costs may be a catastrophe. Moreover, the greater the number of individuals who know they are protected from catastrophic acute costs, the greater the number who will be able to devote personal resources to the potential need for long term care. This, in turn, hopefully will stimulate the market for private long term care insurance.

In addition to the changes already discussed, there are other modifications, which, if passed into law this year, would ensure that the current skilled nursing care benefit is utilized as Congress intended.

Congress has already recognized some aspects of the access problems associated with the existing SNF benefit by implementing a Medicare prospective payment system for low-volume SNFs in the Consolidated Omnibus Budget Reconciliation Act (COBRA). In that same legislation, you approved a moratorium on administrative efforts to eliminate Medicare′s waiver of liability for providers who act in good faith to serve beneficiaries′ post-hospital needs. These steps encourage greater participation by long term care providers in the Medicare program. This is an important policy goal in order to meet justified beneficiary expectations. Increased provider participation also enables the health care system to respond effectively to the changes that are the necessary result of the prospective payment system for hospitals. It is essential to examine the entire continuum of care in this current attempt to pass meaningful acute catastrophic coverage.

A recent study by the Genaral Accounting Office demonstrated the fact that 97 percent of hospital discharge planners nationwide are experiencing difficulty in placing Medicare patients in skilled nursing facilities. The GAO study confirms widespread problems with access to post-hospital care, and it is clear that the situation has deteriorated since 1983. In addition to hospital prospective payment, other factors seen as contributing to the access problems include: increased numbers of Medicare patients, increased use of complex medical equipment and other "high-tech" services which must be carried over into the nursing home setting, state regulation of numbers of nursing home beds, and decreases in the number of SNF providers certified to provide care for Medicare patients. As a result, many Medicare beneficiaries are unable to receive the appropriate care to which they are entitled and remain "backed-up" in expensive hospital beds longer than medically necessary awaiting SNF placement.

AHCA urges the Committee, as part of its catastrophic proposal, to include a prospective payment system for all SNFs. By increasing the Medicare participation threshold with an appropriate prospective payment system and more reasonable cost-reporting requirements, the Medicare program can achieve significant savings and enable beneficiaries to receive the appropriate level of service in a less costly setting. A prospective payment system based on case mix reimbursement would attract wider provider participation and allow the health care system to respond to the increasing demand for Medicare SNF services. At a minimum, the current 1500 Medicare patient day per year should be increased to 2500 Medicare days per year.

Another barrier to access that should be eliminated is the three-day prior hospitalization requirement. This requirement is arbitrary, unnecessary, burdensome and no longer consistent with medical practice patterns since the advent of prospective hospital reimbursement. For example, an otherwise healthy senior could undergo a surgical procedure on an outpatient basis if recovery care and observation in a skilled nursing facility were accessible. AHCA believes that this change would provide Medicare beneficiaries greater flexibility of services and would result in lower program costs for both the Medicare program and the patient.

While we commend the Congress for its recent action to maintain the Medicare waiver of liability for SNFs , a growing number of retrospective denials of SNF claims is creating undue hardship for beneficiaries and providers alike. The private fiscal intermediaries and carriers under contract to HCFA are issuing denials of claims for SNF services at an alarming and unprecedented rate. These contractors, with at least the implied authority of HCFA, are tightening eligibility standards to severely constrain

Medicare SNF providers and save money. For example, long term care providers in Florida requested, through the Freedom of Information Act, documentation of denials since 1984 from their fiscal intermediary. They discovered that in 1984 there were 9,084 Medicare days denied, but in 1986, -- just two years later, -- 140,525 Medicare days were denied. In Illinois, data from the provider community reveals that between 1984 and 1985 the number of SNF beds occupied by Medicare-eligible patients decreased by 46 percent yet, during the same period, there was a 337 percent increase in Medicare payment denials.

The committee need not be reminded that these dramatic changes occurred despite the fact that no major legislative changes that could explain this type of effect had been enacted. Paradoxically, the hospital prospective payment system should have produced just the opposite effect because patients are being discharged faster and in greater need of post-hospital care. Patterns show that decisions on coverage are both arbitrary and capricious. Identical claims, which have been denied when submitted to one office of a fiscal intermediary, are paid when submitted to another office of the same company.

AHCA urges an investigation of HCFA actions as they relate to this issue and enactment of legislation which requires HCFA to provide reasonable access to all standards, guidelines and procedures used in making coverage and payment decisions under Part A and Part B of Medicare. Interpretations of Medicare benefits likely to have substantial impact on the public should be open to public comment. Fiscal intermediaries and carriers should be required to publish and provide reasonable access to all insurance industry rules and other screening devices used in making coverage determinations. HCFA should develop and publish its decision criteria, including provision for public notice and comment, for issuing national coverage determinations. We believe this legislative action is necessary to ensure consistency and to end beneficiary and provider confusion about what are and what are not covered services. With such processes in place, it will be possible to implement a prior authorization system for SNF services. AHCA supports the development of prior authorization as a way to eliminate the need for cumbersome waiver of liability protections and encourages providers to participate in the Medicare program. Hospital discharge planning will be easier and much beneficiary confusion will be eliminated.

At the same time, Congress should develop a less restrictive definition of covered services to close the gap between high level SNF services and home health care. The narrow definition of nursing home coverage being used now is an important barrier to Medicare beneficiaries receiving the services they need. Many patients admitted under the Medicare SNF benefit have stays beyond their Medicare covered days. For example, although a patient stays in a facility for 60 days, Medicare coverage may terminate on Day 15 because the Medicare medical criteria is no longer met. Medicare has not adapted its coverage to account for beneficiary needs or to take advantage of the range of services provided in today's long term care facilities.

The catastrophic proposals which are before us now will not address the overall need for fundamental changes in the way we pay for chronic long term care. But they have opened the debate and legitimized the discussion of this complex issue. Some beginnings must be made, because despite the billions of dollars poured into the Medicare program for FY87 the elderly are paying more and more out of their own pocket for health care. They are paying more in 1987 from personal resources than they did in 1965 when Medicare was enacted. Fundamental changes are necessary to protect today's elderly, tomorrow's middle-aged Americans and their children in the future.

Within the bounds of the acute catastrophic proposals which are before the Congress, there are many ways to improve access to SNF care for Medicare beneficiaries. AHCA looks forward to the opportunity to work with the members and staff of the Ways & Means Health Subcommittee to extend coverage for catastrophic expenses to Medicare beneficiaries.

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Chairman **Stark**. I am hearing about these denials of claims, and in your testimony you talk about Florida increasing from roughly 10,000 days denied in 1986 to 140,000 days denied in 1988. Is that your testimony?

Mr. **Willging**. That is correct.

Chairman **Stark**. Who do you think is doing that? Is there a department or a person that you can identify in HCFA that has suddenly decided that this is a cudgel they are going to pick up? Is it Miller in OMB? Is it Dr. Bowen?

Mr. **Willging**. Quite frankly, although I would like to find the individual, if there were such a person who was responsible for this, I think it stems more from a couple of basic philosophies, Mr. Chairman: one of which is given the constraints on the contractor budgets under the Medicare program, we have a great number of intermediaries vying with each other to curry the favor of the Health Care Financing Administration, particularly given the fact that there is always the specter of competitive procurements. Given the fact that they are rewarded for denials, regardless of whether the denial turns out to have been inappropriate or, indeed——

Chairman **Stark**. How are they rewarded?

Mr. **Willging**. Pardon?

Chairman **Stark**. On commission?

Mr. **Willging**. No, not on commission. In terms of the points they receive on their annual evaluation. If they do not derive sufficient points in terms of the entire array of functions that they are responsible for, they run the risk of losing their contract.

Chairman **Stark**. So I could correct that in two ways: I could take that out of the scheme legislatively, to say you will not award any benefits for denials; or I could switch it to a utilization review, peer review, and put the study of utilization under the existing peer review organizations and not make the denial an administrative one.

Mr. **Willging**. I would add to that a third thing you could do, Mr. Chairman.

Chairman **Stark**. Okay.

Mr. **Willging**. Although the first two would have some benefit, what is needed has already been done on an isolated basis in the past; that is, prospective determinations. Make the coverage decision up front. In fact, the Office of Direct Reimbursement used to do this when it was an intermediary for the Health Care Financing Administration. The patient is being discharged today. Given that patient's condition, we anticipate 20, 25, 45 days of skilled care, so many visits on a home care basis, or, so many therapies as appropriate. Provide that decision up front, subject to reevaluation over time depending upon the condition of the patient.

Chairman **Stark**. Not subject to review? I like the idea that you say 40 days, they will keep them 40 days. And when 35 might be adequate, you will not know that until the 30th day.

Mr. **Willging**. That is correct. I guess at this point we providers—and I suspect the beneficiaries as well—would take almost anything. The recent GAO report suggests 97 percent of all hospital discharge planners cannot find nursing home beds.

Chairman **Stark**. I would like some more details on what we could do, seriously, because I think I will discuss this with HCFA. And if they are not going to do it themselves, then maybe we ought to put something in the legislation. It does not cost anything.

Mr. **Willging**. I would love to work with you on that issue.

Chairman **Stark**. There is no work with me. Just give me an idea or two and let us see if we can do it. That does not sound right to me, and we ought to stop that.

Mr. **Willging**. I admire your insight. It is not right.

Chairman **Stark**. Thank you.

Mr. Rother from the American Association of Retired Persons, proceed.

## STATEMENT OF JOHN ROTHER, DIRECTOR, DIVISION OF LEGISLATION, RESEARCH, AND PUBLIC POLICY, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. **Rother**. Thank you, Mr. Chairman.

I want to begin by complimenting you for an excellent hearing today. Many of the points made in my full statement have already been made, so I will confine myself to about six or seven points that I think have not yet been made this morning.

To begin with, clearly the picture of the need in the older population has changed dramatically since Medicare was enacted. Today we have a much higher prevalence of chronic illness and disability vis-a-vis acute problems, and I think that any reexamination of the need that is out there has to have a much more balanced approach to chronic and acute than our present health care reimbursement system embodies.

Second, it is going to be impossible to manage our health care system effectively unless both of those elements—acute and chronic—are brought in together. I think that is the point that Bruce Vladeck made. It is the experience of other countries, particularly Canada. We have an interactive health care delivery system, but we only have a Federal reimbursement approach to half of it and a very disjointed approach to the other half.

The third point is the public is ready for much more dramatic action in covering long-term care expenses. A recent survey conducted by the Daniel Yankelovich group found that 75 percent of adult Americans would support expanding Medicare to cover long-term care expenses. A survey released just 2 months ago found that 82 percent of Americans aged 45 and over said they would favor a Government program to help pay for long-term care; 72 percent said they would still favor such a program even if it meant a small cost to them personally to help finance it.

The fourth point is that the risk of a formal caregiving support structure undertaking substantially the burdens now being provided for through the family and through informal caregiving is widely overstated. Most of the demonstrations that have been done show that families do not give up their caregiving responsibilities in favor of formal providers when they become available. Indeed, the experience in Canada shows that there was no explosion of demand for long-term care services when those services were included in the provincial health systems.

I would like to reinforce the point the chairman just made. We do have a serious problem in coverage denials, in both the skilled nursing facility and home health care benefits. That problems demands an immediate remedial response. There are other immediate responses to long-term care problems that are also incremental and not that costly, including spousal impoverishment, measures to assure quality in institutional and home health care, a national mandatory income standard for Medicaid eligibility, increasing support services, and greater flexibility for the Medicaid 2176 program.

Nonetheless, even beyond those short-term agenda items, the final point, Mr. Chairman, is simply that this is an area that cries out for a universal approach and an insurance based approach. The risk of institutionalization is widely and dramatically misperceived by the American public. In fact, our latest studies show that the lifetime risk of being in a nursing home is one out of two for all of us alive today. It is one out of four at risk for staying in a nursing home longer than one year. So it is a risk not confined to a small part of the population. We will have to pay the bill anyway. The only question really is how to spread that cost equitably and devise a system that is capable of being managed not only for cost effectiveness, but for the most humane and appropriate level of care.

Thank you very much.

[The prepared statement follows:]

Statement of John Rother, Director, Division of Legislation, Research and Public Policy, American Association of Retired Persons

## Introduction

Thank you, Chairman Stark. I am John Rother, Director of the Legislation, Research and Public Policy Division of the American Association of Retired Persons (AARP). On behalf of the more than 24 million members of AARP, I want to thank you for this opportunity to state the Association's views on long term care financing. I also want to underscore that the Association is very pleased that this Committee, with its jurisdiction over the Medicare program, has chosen to take a close look at the problem of long term care, an issue of increasingly vital concern to millions of American citizens.

I will focus my remarks this morning on five areas: (1) why long term care is a concern within the context of the Medicare program; (2) why we should adopt an insurance rather than a welfare approach to long term care; (3) the burden of long term care expenses on families; (4) some priorities for incremental reforms in 1987; and (5) long term care financing options.

## Why Long Term Care is a Concern Within the Context of Medicare

When Medicare was enacted in 1965, it was designed as an acute care insurance program and was not intended to cover long term care. Today, however, individuals have a much higher probability of experiencing long term, chronic illness than they did two decades ago. This is due both to increasing life expectancy and the fact that life-prolonging medical advances have significantly increased the risk of long term disability for both the young and the old. New medical and surgical techniques, for example, now allow many congenitally impaired infants and traumatically impaired adults to survive to old age. Because the profile of our nation's health care needs has changed, AARP believes it is now as important to insure against the risk of chronic illness as that of acute illness.

In the world of our rapidly changing health care system, rigid distinctions between "acute" and "chronic" illness and "skilled" and "custodial" care break down. Large numbers of hospital admissions, for example, are due to complications from chronic illness, and approximately one-third of admissions to nursing homes are for short-stays, often for recovery from acute illnesses. The needs of the oldest old, those most likely to require long term care, illustrate how difficult it is to separate acute from chronic illness: persons aged 85 and over have the highest rates of acute care hospitalization, as well as the highest rates of chronic disabilities.

Greater continuity of care between acute and long term care settings and between health and social care services is critical to the effective management of our health care system. For example, incomplete rehabilitation from an acute hospitalization often results in a downward trajectory leading to long term dependency and institutionalization. The inability to obtain appropriate social care services, such as help with housework or shopping, can also undermine independent living. Moreover, the lack of medical services in many nursing homes, which increasingly serve a very ill and severely disabled population, has led to unnecessary rehospitalizations in some parts of the nation.

Problems in access to Medicare's skilled nursing and home health care benefits, which sit at the intersection between acute and long term care, are becoming a national scandal. Medicare coverage denials for SNF and home health claims continue to escalate, despite increasing demand for more intensive post-hospital care because of hospital DRGs and very conservative claims submission practices by providers struggling to maintain favorable waiver of liability status. The result has been seriously restricted access to appropriate post-hospital transitional care. According to a January 1987 GAO report, 97% of 850 of the nation's hospital discharge planners are having problems placing Medicare patients in SNFs, and 86% are having similar problems with home health placements. According to the report: "Medicare program rules and regulations were cited as the most important barrier to placing Medicare patients in both skilled nursing facilities and home health care."

Many Americans also do not understand the fact that both Medicare and private insurance exclude coverage for long term illnesses. When people are unhealthy, they do not define their illness as "chronic" rather than "acute" or their need as for "skilled" rather than "custodial" care. They simply know they are ill - and need appropriate care if their condition is not to worsen. The common sense perception that such distinctions are often arbitrary may partially account for the fact that so many Americans erroneously believe that Medicare will cover long term care expenses. It is commonly argued that the remedy for this situation is better public education about existing entitlements. It may, however, be an uphill battle to try to convince Americans that Medicare does not cover something they believe it should cover.

Support for this point comes from several recent AARP sponsored surveys. According to a recent nationwide survey of persons aged 21 and over conducted for AARP by the Daniel Yankelovich Group, more than 3 out of 4 Americans, in all age groups, said that they favor expansion of the Medicare program to include the costs of long term health care which otherwise would be borne by the family. In a December 1986 AARP survey, 82% of Americans aged 45 and over said they would favor a government program to help pay for long term nursing care, and 72% said they would still favor such a program if it meant a small cost to them to help finance it. We view these findings as indicative of the growing public support for change.

## The Case for an Insurance Approach to Long Term Care

It is sometimes asserted that the long term care problem is primarily one of income -- those who can afford long term care services should pay for them, and those who cannot should continue to be protected under Medicaid, a means-tested welfare program.

There are several flaws with this argument. First, aside from the very wealthy, very few persons in our society can afford intensive long term care. Few families, for example, can manage the burden of an extended stay in a nursing home, where costs average nationally around $22,000 per year. Recent research by the Brookings Institution also indicates that only a small proportion of the current and future elderly can afford private long term care insurance. Since the very poor are protected under Medicaid, those most at risk of catastrophic long term care expenses are middle income families, who must deplete their savings of a lifetime in order to afford care. It is inherently inequitable that those unlucky individuals who happen to require nursing home care have to relinquish their life savings, while others do not.

Second, the Association does not believe it is wise to rely upon a welfare program, Medicaid, as our nation's only long term care program, a purpose for which it was never designed. It is questionable whether one could ever remove the social stigma associated with Medicaid, a stigma which prevents many poor Americans, and particularly older Americans, from even applying.

Most important, the very nature of the need for long term care lends itself to an insurance approach based on shared risk: (1) relatively few persons in our society need long term care at any one time; (2) it is nearly impossible to predict who these individuals will be; and (3) the lifetime risk of needing nursing home care is much higher than most people think, i.e., one out of two Americans aged 65 or over will be admitted to a nursing home for at least a short period during the course of his or her lifetime, and one out of 4 will remain in a nursing home for a year or more. These facts argue inherently for universal protection based on an insurance approach to the problem. The costs to any one person will be small, while offering protection to all against catastrophic expenses.

Concerns have been raised that the "floodgates" of demand will be opened and families will shift their responsibilities to formal providers if public benefits for long term care are expanded. Research in the United States, however, shows that families do not significantly reduce the amount of assistance they are providing when formal services are introduced, and that older persons and caregivers tend to underutilize those services which are available in relation to objective need.

The Canadian experience also offers reassurance in this respect. Although most long term care services are available to Canadian citizens at relatively little out-of-pocket cost, family support remains strong and there is little evidence of over-institutionalization. Moreover, the percentage of GNP devoted to health care in Canada, which includes many long term care services under its universal health care system, is significantly less than in the United States, i.e., 8.6% in Canada in 1985 compared with 10.7% in the United States. Although Canadians, like Americans, remain concerned about the costs of long term care, they have kept costs down by requiring co-payments for the "room and board" costs of institutional care, limiting overall budgets, and using care coordinators to channel clients to the most appropriate and cost-effective forms of care.

## The Burden of Long Term Care Expenses on Families

### 1. Community Based Long Term Care

Older people or their relatives are bearing the brunt of practically all of the cost of community-based long term care. The vast majority of long term care (71%) is provided in the community rather than in institutions. Family members are the cornerstone of the long term care delivery system. According to the 1982 National Long Term Care Survey, almost 3 out of 4 functionally impaired older Americans rely exclusively on unpaid sources of care provided by families and friends, and another 21% on a combination of support from families and paid providers. Only 5% of the elderly rely solely on paid providers, and only a small proportion of this paid care is financed through government sources.

### 2. Nursing Home Care

By far the most devastating health care expense for older Americans is that of long term, chronic illness. Nursing home stays account for over 80% of the expenses incurred by older people who experience very high out-of-pocket costs for health care (over $2,000 per year.) Indeed, the amount older persons paid out-of-pocket for nursing home care in 1986, exceeded the amount they paid out-of-pocket that year for all hospital inpatient care, physician services, and drugs combined.

The need for long term care leads almost inevitably to an unmanageable financial burden because the costs of care -- be it in an institution or in the home -- are often enormous. As indicated in Figure 1, Medicare and private insurance combined pay only a miniscule proportion of nursing home costs (less than 3% in 1985). More than half of nursing home costs are paid out of the pockets of residents or their families. Most of the remaining costs are paid under Medicaid.

It is not generally recognized that the proportion of total nursing home costs being paid out-of-pocket has risen substantially in the last decade, i.e., from 42.7% in 1975 to 51.4% in 1985 - an increase of about 20%. (At the same time, the proportion of nursing home costs funded by Medicaid and Medicare has been decreasing.) In absolute terms, the amount Americans were paying out-of-pocket for nursing home care rose from $4.3 billion in 1975 to $18.1 billion in 1985, an increase of 420%. Even when this is corrected for inflation, out-of-pocket spending still more than doubled.

Few people can afford the expense of an extended nursing home stay, so many eventually end up on Medicaid, but only after financial catastrophe has occurred. Almost one-half of Medicaid dollars for nursing home care is spent on behalf of persons who enter nursing homes as private paying residents. The process of "spending-down" one's income and depleting one's assets to qualify for Medicaid can occur very quickly. A 1985 study conducted for the House Aging Committee found that approximately 2/3 of single older persons and 1/3 of couples in Massachusetts were impoverished after only 13 weeks in a nursing home.

As such statistics indicate, the impoverishment of a spouse in the community in order to finance the care of an institutionalized mate is one of the most serious problems facing older couples today. To be eligible for Medicaid, couples must often spend-down their combined income and assets, leaving one spouse - usually the wife - destitute. Many of the same women who are caught in the spend-down problem have spent years taking care of ill and disabled husbands at home.

## Some Priorities for Incremental Reforms in 1987

AARP recognizes the need for the comprehensive reform of the U.S. long term care system, which experts have labeled "a shambles." Indeed, AARP's National Legislative Council recently made long term care reform one of its top priorities. Political realities, however, suggest that the nation is not yet ready to undertake a major overhaul of long term care policies, or to find financing to provide true protection against the catastrophic costs of long term care.

Hence, the Association has selected several incremental steps which would provide urgently needed protection for American families with transitional or long term care needs. We believe that these steps can feasibly be enacted by Congress this year:

o Improve access to the Medicare skilled nursing facility and home health care benefits by:

1. Defining the Medicare home health "intermittent care" requirement to include one or more visits per day on a daily basis by a nurse, therapist, or home health aide for up to 90 days;
2. Eliminating the 3-day prior hospitalization requirement in the SNF Medicare benefit as well as removing the 100-day limit on covered services;
3. Improving program incentives for intermediaries to make accurate coverage determinations (e.g., concerning savings-payback ratios, decisions overturned on appeal, completeness of explanations for denials);
4. Promulgating meaningful and consistent public standards for eligibility for the Medicare skilled nursing facility benefit; and
5. Improving incentives for providers to submit Medicare claims for coverage without being penalized.

o Prevent spousal impoverishment by reserving for spouses an income and asset level that allows them to live with dignity while still permitting the institutionalized spouse to qualify for Medicaid.

o Establish a national mandatory income standard for Medicaid eligibility. Currently, Medicaid eligibility ranges from under 20% of the poverty line in some states to over 90% in others.

o Make the services offered under the Medicaid 2176 program routine Medicaid benefits covered at the option of states. AARP strongly supports the Medicaid 2176 program, but opposes restrictive regulations implementing the program. The services authorized under the waiver -- case management, homemaker/home health aide and personal care services, adult day care, habilitation, and respite care -- are services basic to developing a meaningful system of home and community-based care.

o Increase supportive services, such as respite care and adult day care, for the caregivers to the frail elderly.

o Improve the quality of institutional and home health care.

## Financing Options for Long Term Care

Like many others, AARP is concerned about how to finance high quality long term care services in the community and in institutions, and we are exploring a number of options.

### 1. Private Sector Approaches

Responsibility for long term care insurance must be shared between the public and private sectors of our economy. AARP encourages the development of several private sector approaches, as at least partial solutions, to the problem of financing the long term care system the nation needs.

Efforts to develop private long term care insurance products must be accelerated, and long term care coverage should be offered as an optional benefit under group health plans. AARP recognizes, however, that private insurance is not affordable by many older persons, that coverage for home care is often limited, and that many plans are not indexed for inflation. It also recognizes that better coverage and affordability are trade-offs. Another limitation is that most insurers, who are uncertain about demand, pricing, and the long term claims experience, are not aggressively marketing long term care products. Research is needed on risk analysis, reserve requirements, and the potential of induced demand in both institutional and home care settings. It is not realistic to expect that, in the near-term, a large number of high quality policies will be available on the open market.

AARP and other groups are working to overcome the obstacles to developing viable long term care policies. In conjunction with Prudential, AARP is offering a policy to its own members in certain states which provides a 3 year nursing home benefit and a 365 visit home health benefit, neither of which require a prior hospital or nursing home stay. When the product was test marketed in 8 states in the fall of 1986, almost 8,000 individuals purchased policies. Regulatory approval to offer the policy in the remaining states is being sought. The Association anticipates offering the current product with somewhat higher benefits to all of its members in mid-June. We want to underscore, however, that we do not view long term care insurance as a panacea and that, at best, it will be only one piece of a much broader financing plan.

Social health maintenance organizations (SHMOs) bring together private and public resources to provide a wide range of acute and long term care services. Because the SHMO demonstrations underway at four sites around the nation will yield data critical to evaluating managed care systems for the elderly, Congress should extend their waivers. AARP is hopeful that SHMOs will demonstrate the ability to provide high quality care at a reduced cost.

While AARP encourages the development of home equity conversion plans, which can be used to finance long term services, there is reason to be cautious about how such plans are designed and implemented. For example, persons must be protected from plans that undervalue their homes and against the possibility of default on the part of lenders or buyers.

An exclusive or even a predominant reliance upon private sector approaches is not likely to be a viable solution to the long term care financing problem. Research by the Brookings Institution indicates that private approaches are unlikely to finance more than a modest proportion of total long term care expenditures and would lead to only small reductions in the numbers of persons "spending down" onto Medicaid.

### 2. Public Sector Approaches

AARP believes that universal insurance coverage is needed to solve the problem of catastrophic long term care expenses and that public expenditures for this purpose will need to rise. If spread across people's working lives, comprehensive long term care coverage is certainly affordable. Moreover, these funds for insurance would come from shifting the burden away from the few who must now bear the brunt of the load to a broader population.

The Association wants to work with Congress to find realistic solutions to the long term care financing problem, and we are studying various mechanisms which could be used to fund an expanded public program. These include Medicare premiums, premiums linked to the income tax structure, and payroll taxes. In evaluating various possibilities, we are guided by several general assumptions:

- The burden of paying for long term care should be shared between the retired and the working-age populations;
- Any new federal commitment to funding long term care should be fully funded; we do not want to add to the federal deficit.
- Mechanisms will need to be established to keep providers' costs at reasonable levels and to control utilization;
- Institutional and policy reforms must accompany any major financing change. For example, the system must be "incentive neutral" with respect to where benefits are provided. There should be no financial incentive to use home care over institutional care or vice versa.

## Conclusion

A program to provide universal protection against the catastrophic risk of long term care expenses is the missing piece of the social insurance agenda needed to provide a true "safety net" for American citizens. This is an issue which concerns everyone in our society, not just the elderly. Today, neither the young nor the old have any protection against ruinous long term care expenses, a risk which can devastate middle income families. It is impossible for those who are aware of this situation - and growing numbers are - to feel secure about their own future or that of their loved ones.

Because the greatest fear of older Americans is of becoming a burden on their families or being forced to enter a nursing home and spend their lifetime savings, there is no more important issue for AARP than the reform of our nation's long term care policies. We are pleased to offer our resources and assistance in finding solutions to what we believe will be one of the most pressing social issues of the late 1980's and early 1990's.

Chairman STARK. Thank you. I am sorry to be a little distracted here, but the Florida figures upset me.

Do you have any idea what the dollar volume of the claims denied was, Dr. Willging? Can I just go back to that a minute?

Mr. WILLGING. I do not have that with me, but I can probably get that and submit it for the record, Mr. Stark.

Chairman STARK. Would you want to make a guess? You are saying that about 130,000 days were denied. Now, that is in a year, right?

Mr. WILLGING. 40,000 days——

Chairman STARK. 130,000 more days. In other words, 2 years before you had 10,000. Let us assume that with more efficiency they would get it up to 20,000. Let us just say there is a change in the method that netted 100,000 Medicare days. What is that worth?

Mr. WILLGING. 100,000 Medicare days at approximately, just for the sake of argument, $100 per day. I am a political scientist; therefore, I cannot compute that quickly.

We are talking, I would think, Mr. Chairman, anywhere from $150 to $200 million per year in denials alone.

Chairman STARK. Just in Florida? Because your figures are Florida alone.

Mr. WILLGING. A quick computation here; 60 times 100,000.

Chairman STARK. Now, is there a copay in that?

Mr. WILLGING. Were those claims not denied, there would have been a copay starting on the 21st day, yes.

Chairman STARK. Okay. So it is 100,000 days times how much a day?

Mr. WILLGING. We are also talking——

Chairman STARK. How much a day, again?

Mr. WILLGING. The Medicare average is $65 to $70 per day of skilled care; home care is a different issue.

Ms. Hollers. Because it is per visit rather than per day.

Mr. WILLGING. Per visit.

Chairman STARK. So give me an average figure per day.

Mr. ROTHER. I would suggest using $50 a day as a rough guide, if you want to just average it out.

Chairman STARK. Okay. Let me just make a suggestion to you. Does the American Health Care Association want to turn activist in its——

Mr. WILLGING. Pardon me, Mr. Chairman?

Chairman STARK. I would figure those chintzy people would figure out a way to skew the system. There is a Stark Amendment that was passed last year that says they cannot make a policy change that saves more than $25 million a year without our approval, congressional approval. I think you have got a lawsuit if you guys want to go after it to recover.

Ms. HOLLERS. We are currently suing them.

Chairman STARK. Under that provision?

Ms. HOLLERS. No.

Chairman STARK. I think it is illegal. I think what I am seeing is that if you can prove that there was a policy change—and I will have Dr. Roper here to talk about that tomorrow. But it should not have been done, as jealous as we are of jurisdiction, without talking with us first. That is absolutely outrageous.

I am sorry. I did not mean to go on. I want to talk some more about some things with AARP in a second.

Mr. Rother. If I could comment just on that one point, though, I think you do raise a very important issue. And combine that with the fact that hospitals today are making out very well under the Medicare system, and I think what you have is a failure of policy to keep up with the shift in the site of care.

As we shifted care to an outpatient basis, reimbursement policy has not shifted the resources the same way, and I think we have an opportunity to do something about that now.

Chairman Stark. Ms. Hollers, make me feel better.

## STATEMENT OF KAY HOLLERS, R.N., M.P.H., CHAIR, GOVERNMENT AFFAIRS COMMITTEE, NATIONAL ASSOCIATION FOR HOMECARE, AND PRESIDENT OF WELLSTREAM HEALTH SERVICES, INC. OF AUSTIN, TX

Ms. Hollers. Thank you. I, too, am going to go very quickly in a summary fashion.

I think we need to look at that whole issue of where long-term care is practiced and by whom it is practiced. The members of the National Association for Homecare, some 5,000 home health agencies, homemaker home health aide organizations and hospices, agree with the findings of the General Accounting Office (GAO) report mentioned in earlier testimony. That report found that millions of seniors are going without the care they need. Of an estimated 3.2 million persons who needed help in performing daily functions, only 1.9 million claimed that they got the support they needed, and of those only 8 percent were getting that support through paid sources. So clearly, the majority of long-term care is being provided in homes and in the community, and the huge bulk of that is being provided by unpaid family caregivers.

The GAO report also makes a compelling case for the more efficient administration of the home health benefit and for its expansion to help meet the needs of those homebound elderly people. Our task and your task is to figure out ways to do that without shifting the cost of care presently being provided by relatives into the Federal Treasury. I think we are all sensitive to that and realize that is what you need to do.

As Bruce Vladeck mentioned earlier, there are several issues that are currently presenting barriers to use by beneficiaries of the Medicare benefit as it exists today in even meeting the acute care needs of people. I think those are some of the issues that we were just discussing regarding the HCFA interpretation of policies. The primary issues which are giving us the most difficulty currently in this regard are the interpretation of the intermittent care requirement and the homebound requirement.

We understand that Congressman Roybal is planning to introduce the Catastrophic Acute and Transitional Care Act, which is a proposal to complete the Medicare acute care benefit by adding, among other services, transitional services to assist beneficiaries to remain in their homes. This bill would also enact the clarifications of those intermittent and homebound requirements which we recommend. We see that bill as a first step in addressing acute care needs before we even get into the long-term care aspects of the problem.

Once we move into the long-term care or chronic care issues, there are four possible alternatives that we see that would be helpful in addressing these problems. The first is the bill that was introduced last week by Congressmen Daub and Donnelly of your committee numbered H.R. 1776, or the Medicare Long-Term Care Amendments of 1987, that would allow Medicare reimbursement of home health services without regard to the current part-time and intermittent care requirements, as well as a wider range of nursing home care.

The bill would resolve many of the problems beneficiaries have faced in becoming eligible for the health services which would allow them to remain in their homes, while not greatly expanding the range of services offered under the Medicare home health benefit.

We do have some concerns with what seems to be a high deductible included in the bill. We are not sure what the effect of that deductible would be on access to care, but we certainly welcome the relaxation of those troublesome provisions regarding intermittent care that have given us so much trouble with the current benefit.

The second alternative of which we are aware is that proposed by Congressman Pepper, which would furnish comprehensive catastrophic benefits, including comprehensive long-term care services, H.R. 65. The bill deletes the intermittent care and the skilled nursing care requirements and would expand the coverage of other home and community based long-term care services. However, given the recent problems with Medicare risk contracts with HMOs, we are concerned that the capitated approach used in the bill really requires further study before being implemented on such a large scale.

Chairman STARK. Yes, you had better believe it.

Ms. HOLLERS. The third approach, and one that I think deserves a lot of study, is an approach which might require Medicare to pay for home care up to a maximum of what would otherwise be spent on the care of a patient in an institution, similar to the coverage provided under the current Medicaid home and community based care waivers.

An example of such a program is the Nursing Home Without Walls program that is in use in New York, where the availability of a broad range of alternative services is provided, but by statute the cost is limited to 75 percent of what the cost would be to care for the patient in the nursing home. This uses a case management approach.

A less sweeping approach would be to implement a similar program without case management but allowing a very limited personal care benefit to provide some of those support services that currently are barring people from using home health because they do not at that moment need skilled health services.

Thank you very much for allowing us to bring these concerns and alternatives for long-term coverage to you.

[The prepared statement follows:]

## STATEMENT OF
## KAY HOLLERS
## NATIONAL ASSOCIATION FOR HOME CARE

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I AM KAY HOLLERS, PRESIDENT OF WELLSTREAM HEALTH SERVICES, INC., OF AUS
TEXAS. I AM ALSO CHAIRMAN OF THE GOVERNMENT AFFAIRS COMMITTEE OF
NATIONAL ASSOCIATION FOR HOME CARE (NAHC).

NAHC IS THE LARGEST PROFESSIONAL ORGANIZATION REPRESENTING THE INTERESTS
HOME HEALTH AGENCIES, HOMEMAKER-HOME HEALTH AIDE ORGANIZATIONS
HOSPICES, WITH APPROXIMATELY 5,000 MEMBER ORGANIZATIONS. NAHC IS COMMIT
TO ASSURING THE AVAILABILITY OF HUMANE, COST-EFFECTIVE, HIGH QUALITY HOME C
SERVICES TO ALL WHO REQUIRE THEM.

WE APPRECIATE THIS OPPORTUNITY TO ADDRESS THE ISSUE OF LONG-TERM CA
BECAUSE THE MAJORITY OF THE PATIENTS WE SERVE ARE THE FRAIL ELDERLY WHO
MOST AT RISK OF NEEDING LONG-TERM HEALTH CARE SERVICES. WE ARE PLEASED T
DISCUSSION OF PROPOSED CATASTROPHIC HEALTH INSURANCE PROPOSALS
INCREASED PUBLIC AWARENESS ABOUT THE ACTUAL "CATASTROPHIC" HEALTH NEE
OF THE ELDERLY-THE NEED FOR COVERAGE OF LONG-TERM CARE IN THEIR HOMES,
WHEN THAT IS IMPOSSIBLE, IN APPROPRIATE INSTITUTIONS.

### I. THE NEED FOR LONG-TERM COVERAGE

THE FUNDAMENTAL HEALTH CARE NEED OF ELDERLY AMERICANS IS NOT COVERAGE
COSTLY "CATASTROPHIC" ACUTE ILLNESSES, BUT RATHER THE COVERAGE OF THE
MORE COSTLY CARE NEEDED FOR CHRONIC CONDITIONS.

A RECENT REPORT BY THE GENERAL ACCOUNTING OFFICE 1/ ANALYZED DATA FROM
1982 NATIONAL LONG-TERM CARE SURVEY AND FOUND THAT MILLIONS OF SENIORS
GOING WITHOUT THE CARE THEY NEED.

ACCORDING TO THE 1982 DATA, AN ESTIMATED 3.2 MILLION ELDERLY NEEDED HEL
PERFORMING SUCH FUNCTIONS AS EATING, DRESSING, PREPARING MEALS, GETTIN
OR OUT OF BED, AND GOING TO THE BATHROOM. OF THIS NUMBER, ONLY 1.9 MILL
CLAIMED TO HAVE THE SUPPORT THEY NEEDED, SOME 71 PERCENT OF WHICH
PROVIDED BY RELATIVES. ANOTHER 21 PERCENT WAS PROVIDED BY A COMBINATION
UNPAID AND PAID CARE. ONLY 8 PERCENT OF THOSE WHO FELT THEIR NEEDS W
BEING MET RELIED EXCLUSIVELY ON PAID CARE. THE REPORT STRESSES T
NONCOVERED SERVICES ARE NOT NECESSARILY UNNEEDED SERVICES.

THE GAO REPORT MAKES A COMPELLING CASE FOR MORE EFFICIENT ADMINISTRATION
THE HOME HEALTH BENEFIT AND FOR ITS CAREFUL EXPANSION TO MEET THE NEEDS
THE HOMEBOUND AND DEPENDENT ELDERLY WITHOUT SHIFTING THE COST OF C
PRESENTLY PROVIDED BY RELATIVES TO THE FEDERAL TREASURY.

THE CURRENT MEDICARE HOME HEALTH BENEFIT IS A LIMITED ONE. IT COVERS O
THOSE ACUTE SERVICES NEEDED ON AN "INTERMITTENT" BASIS, THAT IS, DAILY VIS
FOR A TWO TO THREE WEEK PERIOD, AND THEREAFTER UNDER EXCEPTIO
CIRCUMSTANCES. TO BE ELIGIBLE FOR HOME HEALTH CARE UNDER MEDICAR
PERSON MUST BE CONFINED TO HIS OR HER RESIDENCE (ESSENTIALLY HOMEBOU
BE UNDER THE CARE OF A PHYSICIAN, AND NEED PART-TIME OR INTERMITTENT SKIL
NURSING SERVICES (AS OPPOSED TO DAILY 24 HOUR-A-DAY CARE) AND/OR PHYSICAL
SPEECH THERAPY. IF THESE REQUIREMENTS ARE MET, A PERSON IS ELIGIBLE FOR
FOLLOWING SERVICES: SKILLED NURSING SERVICE, PHYSICAL THERAPY, SPEE
THERAPY, OCCUPATIONAL THERAPY, MEDICAL SOCIAL WORK, AND HOME HEALTH A
SERVICES.

THE MEDICARE HOME HEALTH BENEFIT DOES NOT COVER ALL ACUTE CARE NEEDS,
ANY CHRONIC CARE NEEDS.

### II. THE FIRST STEP: IMPROVE MEDICARE ACUTE CARE COVERAGE

WHILE WORKING ON A MEANINGFUL LONG-TERM CARE PROGRAM HOME CARE BENE
CONGRESS SHOULD IMMEDIATELY TAKE STEPS TO REMEDY PROBLEMS IN THE CURR
MEDICARE HOME HEALTH BENEFIT THAT ARE LIMITING ACCESS TO THE BENEFIT FOR M
MEDICARE BENEFICIARIES.

1/GENERAL ACCOUNTING OFFICE, "MEDICARE: NEED TO STRENGTHEN HOME HEALTH CARE PAYMENT CONTROLS AND ADDRESS UNMET NEEDS", HRD-87-9, DECEMBER 1986.

RECENT POLICIES OF THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) "TO RESTRAIN BENEFICIARY PROTECTIONS, COMBINED WITH VAGUE AND CONFUSING GUIDELINES FOR PROVIDERS, RESULT IN REDUCED ACCESS TO HOME HEALTH CARE FOR OLDER AMERICANS", ACCORDING TO A REPORT BY THE SENATE SPECIAL COMMITTEE ON AGING.[2/] THE REPORT NOTED THAT ALTHOUGH HOSPITAL DISCHARGES TO HOME HEALTH HAVE INCREASED 37 PERCENT SINCE PROSPECTIVE PAYMENT FOR HOSPITALS WAS IMPLEMENTED, THE GROWTH IN HOME HEALTH SERVICES SINCE THEN HAS SLOWED. A RECENT GENERAL ACCOUNTING OFFICE SURVEY[3/] OF HOSPITAL DISCHARGE PLANNERS REVEALED THAT 86 PERCENT "REPORTED PROBLEMS WITH HOME HEALTH CARE PLACEMENTS" FOR MEDICARE BENEFICIARIES. FIFTY-TWO PERCENT OF THOSE SURVEYED CITED "MEDICARE PROGRAM RULES AND REGULATIONS" AS "THE MOST IMPORTANT BARRIER" TO THESE PLACEMENTS. IT IS NO COINCIDENCE THAT HCFA'S OWN STATISTICS SHOW THAT THE PERCENTAGE OF MEDICARE HOME HEALTH CLAIMS DENIED ROSE FROM 1.2 PERCENT IN 1983 TO OVER 6.0 PERCENT IN 1986. AND THIS FIGURE DOES NOT INCLUDE THE MANY PATIENTS WHO ARE EFFECTIVELY DENIED MEDICARE COVERAGE BECAUSE HOME HEALTH AGENCIES, INCAPABLE OF ASSUMING THE COSTS OF NON-COVERED CARE, AVOID MEDICARE CLAIMS SUBMISSIONS.

## A. INTERMITTENT CARE REQUIREMENT

AS NOTED EARLIER, THE PRESENT HCFA GUIDELINES ALLOW FOR DAILY VISITS FOR A TWO TO THREE WEEK PERIOD, AND THEREAFTER, VISITS MAY BE CONTINUED UNDER EXCEPTIONAL CIRCUMSTANCES. THIS LEVEL OF SERVICES IS OFTEN INADEQUATE TO CARE FOR MORE ACUTELY ILL PATIENTS WHO ARE BEING DISCHARGED FROM HOSPITALS.

IN ADDITION, DEFINITIONS OF WHAT CONSTITUTES "INTERMITTENT CARE" VARY TREMENDOUSLY, DEPENDING ON THE FISCAL INTERMEDIARY'S (FI's) INTERPRETATION. AS A RESULT, MEDICARE, WHICH IS SUPPOSED TO BE A NATIONAL PROGRAM, IS NOT ENFORCED UNIFORMLY AND WHAT IS COVERED FOR ONE BENEFICIARY IN ONE STATE IS NOT COVERED IN OTHER STATES.

A RELATED PRACTICE, KNOWN AS "SELECTIVE BILLING," HAS SERVED TO FURTHER RESTRICT HOME CARE COVERAGE FOR MEDICARE BENEFICIARIES. IF PATIENTS ARE RECEIVING COVERAGE UNDER MEDICARE, IN MANY CASES THEY CANNOT RECEIVE ADDITIONAL COVERAGE FROM MEDICAID OR ANY OTHER PAYMENT SOURCE (PRIVATE INSURANCE, SELF-PAY, TITLE XX, ETC.). FOR EXAMPLE, IF A PATIENT IS RECEIVING 3 HOURS OF NURSING CARE AND 2 HOURS OF AIDE CARE FOR 3 DAYS A WEEK PAID FOR BY MEDICARE, AND HE OR HIS FAMILY WANTS AN ADDITIONAL 2 HOURS OF NURSING CARE ON THE OTHER 2 DAYS WHICH WILL BE PAID BY CONCERNED RELATIVES, FISCAL INTERMEDIARIES WILL DENY THE MEDICARE COVERAGE, CLAIMING THAT THE PATIENT IS EXCEEDING THE "INTERMITTENT CARE" REQUIREMENT. THIS WILL EITHER RESULT IN NO CARE, LIMITED CARE, OR THE FORCED INSTITUTIONALIZATION OF AN INDIVIDUAL WHOSE FAMILY CANNOT SUSTAIN HIM AT HOME IF MEDICARE REFUSES TO PAY ITS FAIR SHARE.

## B. HOMEBOUND REQUIREMENT

THE MEDICARE HOMEBOUND GUIDELINE ALLOWS THE PATIENT TO BE CONSIDERED HOMEBOUND IF HE HAS INFREQUENT OR SHORT DURATION ABSENCES FROM THE HOME PRIMARILY FOR MEDICAL TREATMENT OR "OCCASIONAL NON-MEDICAL PURPOSES" (E.G., TRIP TO BARBER, A DRIVE, WALK AROUND THE BLOCK).

THE CURRENT DEFINITION IN THE GUIDELINES IS INTERPRETED IN AN INCONSISTENT AND VARYING MANNER BY FISCAL INTERMEDIARIES. THIS IS ESPECIALLY SO IN CASES WHERE BENEFICIARIES ARE LEAVING THEIR HOMES TO GO OUT FOR PERIODIC ADULT DAY CARE, OUTPATIENT KIDNEY DIALYSIS, CHEMOTHERAPY AND OTHER SIMILAR TREATMENT. EVEN THOUGH THE CURRENT GUIDELINE ALLOWS BENEFICIARIES TO GO OUT FOR MEDICAL

[2/] U.S. SENATE SPECIAL COMMITTEE ON AGING, "THE CRISIS IN HOME HEALTH CARE: GREATER NEED, LESS CARE", JULY 28, 1986.

[3/] GENERAL ACCOUNTING OFFICE, "POST-HOSPITAL CARE: DISCHARGE PLANNERS REPORT DIFFICULTIES IN PLACING MEDICARE PATIENTS", PEMD-87-5BR.

REASONS, SOME FIs SEVERELY LIMIT FREQUENCY AND OTHERS DO NOT HONOR THE MEDICAL REASON EXCEPTION AT ALL. IN SITUATIONS WHERE INDIVIDUALS LEAVE THEIR HOMES FOR EITHER MEDICAL OR NON-MEDICAL REASONS, INDIVIDUAL FIs HAVE THEIR OWN INTERPRETATIONS AS TO WHAT THEY CONSIDER FREQUENT OR INFREQUENT, OR WHETHER THEY CONSIDER THE PATIENT HOMEBOUND IF HE LEAVES HOME WITH THE AID OF AN AMBULANCE OR OTHER EXTRAORDINARY ASSISTANCE.

THESE PROBLEMS WITH THE INTERMITTENT AND HOMEBOUND REQUIREMENTS SHOULD BE REMEDIED AT THE EARLIEST POSSIBLE OPPORTUNITY TO ASSURE ADEQUATE ACCESS TO BENEFICIARIES WHO NEED HOME CARE SERVICES.

WE UNDERSTAND THAT CONGRESSMAN EDWARD ROYBAL IS PLANNING TO INTRODUCE "THE CATASTROPHIC ACUTE AND TRANSITIONAL CARE ACT," A PROPOSAL TO COMPLETE THE MEDICARE ACUTE CARE BENEFIT BY ADDING, AMONG OTHER SERVICES, TRANSITIONAL SERVICES TO ASSIST BENEFICIARIES TO REMAIN IN THEIR HOMES. THE BILL WOULD ENACT THE CLARIFICATIONS OF THE INTERMITTENT AND HOMEBOUND REQUIREMENT WE RECOMMEND. THE BILL WOULD ALSO CLARIFY THAT VISITS LESS THAN 7 DAYS PER WEEK ARE ALLOWED FOR AN UNLIMITED PERIOD OF TIME. IN ADDITION, THE BILL WOULD ADD A RESPITE CARE BENEFIT, TO SUPPORT THE EFFORTS OF FAMILY CAREGIVERS TO KEEP BENEFICIARIES IN THEIR HOMES, AND ADDITIONAL PERSONAL SUPPORT SERVICES AS WELL FOR SHORT PERIODS OF TIME, WHEN NEEDED BECAUSE THE BENEFICIARY LACKS THE TYPE OF SUPPORT SERVICES THAT WOULD ENABLE HIM TO UTILIZE THE HOME HEALTH BENEFIT. THE BILL WOULD ALSO ADD SOME SHORT-TERM REHABILITATIVE SERVICES TO THE MEDICARE HOME HEALTH BENEFIT. WE COMMEND THIS APPROACH TO YOU AS A MEANS FOR COMPLETING THE ACUTE CARE MEDICARE BENEFIT AND AS A FIRST STEP TOWARD CATASTROPHIC PROTECTION.

## III. THE SECOND STEP: A LONG TERM CARE HOME HEALTH BENEFIT

THE SECOND STEP IN CATASTROPHIC PROTECTION SHOULD BE DEVELOPMENT OF A COMPREHENSIVE LONG-TERM PROGRAM WITH A FOCUS ON HOME HEALTH CARE. WE CAN OFFER SEVERAL POSSIBLE FORMS SUCH A BENEFIT SHOULD TAKE.

LAST WEEK CONGRESSMEN DAUB AND DONNELLY INTRODUCED H.R. 1776, THE "MEDICARE LONG-TERM CARE AMENDMENTS OF 1987". THAT BILL WOULD ALLOW MEDICARE REIMBURSEMENT OF HOME HEALTH SERVICES WITHOUT REGARD TO THE CURRENT "PART-TIME" AND "INTERMITTENT CARE" REQUIREMENTS, AS WELL AS A WIDER RANGE OF NURSING HOME CARE. THE BILL WOULD RESOLVE MANY OF THE PROBLEMS BENEFICIARIES HAVE FACED IN BECOMING ELIGIBLE FOR THE HEALTH SERVICES WHICH WOULD ALLOW THEM TO REMAIN IN THEIR HOMES, WHILE NOT EXPANDING THE RANGE OF SERVICES OFFERED UNDER THE MEDICARE HOME HEALTH BENEFIT. WE ARE CONCERNED, HOWEVER, WITH THE HIGH DEDUCTIBLE INCLUDED IN THE BILL (FROM A MINIMUM OF $10,000 TO A MAXIMUM OF $15,000) BECAUSE IT WOULD REQUIRE MANY MEDICARE BENEFICIARIES TO EXHAUST NEARLY ALL THEIR RESOURCES TO BECOME ELIGIBLE.

CONGRESSMAN PEPPER HAS ALSO INTRODUCED H.R. 65, A BILL TO FURNISH COMPREHENSIVE CATASTROPHIC BENEFITS, INCLUDING COMPREHENSIVE LONG- TERM CARE SERVICES PROVIDED IN THE ENVIRONMENT OF LEAST RESTRICTION. THE BILL WOULD DELETE THE "INTERMITTENT CARE" AND "SKILLED NURSING CARE" REQUIREMENTS, AND WOULD EXPAND COVERAGE OF OTHER HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES. GIVEN RECENT PROBLEMS WITH MEDICARE RISK CONTRACTS WITH HMOs, HOWEVER, WE BELIEVE THAT THE CAPITATED APPROACH IN THIS BILL DESERVED FURTHER STUDY BEFORE BEING IMPLEMENTED ON SUCH A LARGE SCALE.

AN ALTERNATE APPROACH MIGHT BE TO REQUIRE MEDICARE TO PAY FOR HOME CARE UP TO A MAXIMUM OF WHAT WOULD OTHERWISE BE SPENT ON THE CARE OF A PATIENT IN AN INSTITUTION, SIMILAR TO COVERAGE UNDER THE CURRENT MEDICAID HOME AND COMMUNITY-BASED CARE WAIVERS. SUCH A PLAN WOULD REQUIRE CASE MANAGERS TO DETERMINE ALTERNATIVE COSTS OF CARE IN SETTINGS AND TO COORDINATE MEDICARE SERVICES WITH OTHER SERVICES PROVIDED IN THE COMMUNITY, SUCH AS ADULT DAY CARE. ONE EXAMPLE OF SUCH A PROGRAM IS THE "NURSING HOME WITHOUT WALLS" PROGRAM IN NEW YORK, WHERE THE AVAILABILITY OF A BROAD RANGE OF ALTERNATIVE SERVICES HAS NOT ONLY MAINTAINED THE FRAIL ELDERLY IN THEIR OWN HOMES, BUT HAS DONE SO AT AN AVERAGE OF 50 PERCENT OF THE COSTS THAT WOULD OTHERWISE BE INCURRED FOR THE PATIENT IN A NURSING HOME.

THE "NURSING HOME WITHOUT WALLS" PROGRAM COORDINATES AND MANAGES THE DELIVERY OF ALL SERVICES TO THE PATIENT, AND THE LOCAL DEPARTMENT OF SOCIAL SERVICES MONITORS THE PATIENT'S MONTHLY CARE COSTS. IN ADDITION TO REGULAR MEDICAID SERVICES, THE PROGRAM ALSO OFFERS MEDICAL SOCIAL SERVICES, NUTRITIONAL COUNSELING, RESPIRATORY THERAPY, RESPITE CARE, SOCIAL DAY CARE, CONGREGATE/HOME DELIVERED MEALS, MOVING ASSISTANCE, HOUSING IMPROVEMENT, HOME MAINTENANCE, SOCIAL TRANSPORTATION, PERSONAL EMERGENCY RESPONSE SYSTEMS, AND CASE MANAGEMENT. BY STATUTE, COSTS FOR THE PROGRAM MAY NOT EXCEED 75 PERCENT OF THE AVERAGE MONTHLY COST OF INSTITUTIONAL CARE. AS MENTIONED EARLIER, DESPITE THESE ADDITIONS IN SERVICES, THE PROGRAM IS SAVING AN AVERAGE OF 50 PERCENT OF THE COSTS THAT WOULD OTHERWISE BE INCURRED FOR THAT PATIENT IN A SKILLED NURSING FACILITY OR INTERMEDIATE CARE FACILITY.

A LESS SWEEPING BENEFIT, WHICH COULD BE PROVIDED WITHOUT THE DEVELOPMENT OF A CASE MANAGEMENT SYSTEM FOR MEDICARE, COULD BE PROVIDED BY COVERING A LIMITED AMOUNT OF PERSONAL CARE, FOR EXAMPLE, A SPECIFIED NUMBER OF HOURS OF PERSONAL CARE PER WEEK TO MAINTAIN FUNCTIONALLY IMPAIRED INDIVIDUALS IN THEIR HOMES. THIS TYPE OF CARE WOULD PROVIDE A RESPITE FOR FAMILIES TO ENABLE THEM TO CONTINUE TO TAKE CARE OF OLDER OR DISABLED FAMILY MEMBERS IN THEIR HOMES. IT WOULD ALSO PROVIDE SERVICES TO PERSONS WHOSE OTHER NEEDS CAN BE MET BY FAMILY AND NEIGHBORS WHERE THE CAREGIVERS MAY BE RELUCTANT OR UNABLE TO PROVIDE SUCH PERSONAL CARE SERVICES AS BATHING. THESE PERSONAL CARE SERVICES WOULD SUPPLEMENT CURRENT COMMUNITY-BASED EFFORTS, NOT REPLACE THEM. SUCH ASSISTANCE AS PART OF THE MEDICARE PROGRAM COULD INCREASE THE SITUATIONS IN WHICH THESE PATIENTS COULD REMAIN IN THEIR HOMES RATHER THAN BEING PLACED IN NURSING HOMES.

WE BELIEVE THAT FINANCING FOR ENHANCED HOME HEALTH COVERAGE SHOULD BE THROUGH MANDATORY FINANCIAL PARTICIPATION SPREAD OVER THE LIVES OF WORKERS, SIMILAR TO CURRENT MEDICARE PART A FINANCING. SUCH A METHOD WOULD MINIMIZE THE IMPACT BY DISTRIBUTING THE FINANCING OVER THE LARGEST POSSIBLE NUMBER OF INDIVIDUALS IN A PROGRESSIVE MANNER.

## IV. THE ROLE OF GOVERNMENT IN LONG-TERM CARE

THE PROBLEM OF LONG-TERM CARE IS OF SUCH MAGNITUDE THAT IT DEMANDS ATTENTION FROM BOTH THE FEDERAL AND STATE GOVERNMENTS, AS WELL AS FROM THE PRIVATE SECTOR AND CONSUMERS. THE FEDERAL GOVERNMENT MUST TAKE THE LEAD IN PROVIDING ADEQUATE COVERAGE FOR LONG-TERM CARE NEEDS. THE PROBLEM OF LONG-TERM CARE REQUIRES A NATIONAL APPROACH TO PROVIDE A MINIMUM RANGE OF SERVICES, WHICH CAN BE SUPPLEMENTED BY THE PRIVATE SECTOR.

STATE GOVERNMENTS ALREADY PLAY AN IMPORTANT ROLE IN LONG-TERM CARE BY FINANCING A LARGE PERCENTAGE OF THE NURSING HOME CARE IN AMERICA. STATE MEDICAID PROGRAMS ALSO PROVIDE A RANGE OF HOME HEALTH SERVICES. ESTABLISHING AN APPROPRIATE FEDERAL ROLE IN LONG-TERM CARE WOULD DECREASE FINANCIAL PRESSURES ON STATES' MEDICAID PROGRAMS. IT WOULD ALSO AVOID THE DISGRACEFUL SITUATION IN THIS COUNTRY WHERE THE ELDERLY ARE FORCED TO IMPOVERISH THEMSELVES IN ORDER TO OBTAIN MEDICAID COVERAGE FOR THEIR LONG-TERM CARE NEEDS.

THE PRIVATE SECTOR SHOULD BE ENCOURAGED TO OFFER LONG-TERM CARE INSURANCE POLICIES THAT SUPPLEMENT MEDICARE. IN ADDITION, CONSUMER SAVINGS TO MEET LONG-TERM CARE NEEDS SHOULD BE ENCOURAGED THROUGH TAX-DEDUCTIONS OR TAX-DEDUCTIBLE INDIVIDUAL MEDICAL ACCOUNTS.

H.R. 1776, THE DAUB-DONNELLY "MEDICARE LONG TERM CARE AMENDMENTS OF 1987", WOULD ALLOW INDIVIDUALS OVER 50 TO TAKE, AS AN ABOVE-THE LINE DEDUCTION FOR INCOME TAX PURPOSES, THE COST OF LONG-TERM CARE INSURANCE PREMIUMS. IN ADDITION, PENSION PLANS WOULD BE PERMITTED TO OFFER LONG-TERM HEALTH CARE BENEFITS FOR CURRENT AND RETIRED EMPLOYEES. WE BELIEVE THAT THIS PLAN (TOGETHER WITH ITS PROTECTIONS REGARDING ELIGIBLE INSURANCE PLANS) IS A SOUND PROPOSAL TO ENCOURAGE BOTH THE INSURANCE INDUSTRY AND CONSUMERS TO PLAN FOR FUTURE LONG-TERM CARE NEEDS.

WE WISH TO STRESS, HOWEVER, THAT THESE ENDEAVORS BY STATE GOVERNMENTS, THE PRIVATE INSURANCE INDUSTRY, AND CONSUMERS SHOULD BE SUPPLEMENTAL TO THOSE OF THE FEDERAL GOVERNMENT IN ADDRESSING THE NEEDS OF THE ELDERLY FOR LONG-TERM CARE.

## V. SUMMARY - RECOMMENDATIONS:

CONGRESS SHOULD:

1. CLARIFY THE DEFINITION OF INTERMITTENT CARE TO INCLUDE ONE OR MORE VISITS PER DAY ON A DAILY BASIS FOR UP TO 90 DAYS AND THEREAFTER UNDER EXCEPTIONAL CIRCUMSTANCES. VISITS LESS OFTEN THAN ONE A DAY SHOULD BE PERMITTED FOR AN INDEFINITE PERIOD OF TIME. DAILY CARE SHOULD BE CLARIFIED TO MEAN SEVEN DAYS PER WEEK.

2. CLARIFY THAT A MEDICARE PATIENT SHOULD BE ABLE TO UTILIZE ADDITIONAL PAYMENT SOURCES WITHOUT JEOPARDIZING HIS MEDICARE BENEFIT, AS LONG AS THE CARE PAID FOR BY MEDICARE IS MEDICALLY REASONABLE AND NECESSARY. THE USE OF OTHER PAYORS SHOULD NOT BE RELEVANT TO DETERMINATIONS OF MEDICARE COVERAGE.

3. CODIFY THE CURRENT HOMEBOUND GUIDELINE AND CLARIFY THAT AN INDIVIDUAL NEED NOT BE TOTALLY DEPENDENT AND BEDRIDDEN TO BE CONSIDERED HOMEBOUND.

4. ENACT A LONG-TERM CARE PLAN WITH A MEANINGFUL HOME CARE BENEFIT AS ITS FOCUS. THAT HOME CARE BENEFIT SHOULD DELETE THE PART TIME AND INTERMITTENT CARE REQUIREMENTS AND ALLOW MEDICARE TO PAY FOR HOME CARE UP TO A MAXIMUM OF WHAT WOULD OTHERWISE BE SPENT ON THE CARE OF A PATIENT IN AN INSTITUTION, SIMILAR TO MEDICAID HOME AND COMMUNITY-BASED WAIVERS. A LESS SWEEPING BENEFIT, WHICH COULD BE PROVIDED WITHOUT THE DEVELOPMENT OF A CASE MANAGEMENT SYSTEM FOR MEDICARE, COULD BE PROVIDED WITH MEDICARE COVERING A LIMITED AMOUNT OF PERSONAL CARE PER WEEK, TO ASSIST FAMILY AND COMMUNITY CAREGIVERS IN MAINTAINING FUNCTIONALLY DISABLED INDIVIDUALS IN THEIR HOMES.

MR. CHAIRMAN, I APPRECIATE HAVING THE OPPORTUNITY TO TESTIFY TODAY ON THESE IMPORTANT MATTERS. I WOULD BE PLEASED TO ANSWER ANY QUESTIONS YOU MIGHT HAVE.

Chairman **Stark**. Thank you.

What I must say, and I do not mean to be harsh, but you are a person here way ahead of her time. We have to put aside the issues that you raise in your testimony, if I had to guess an order of magnitude, 5 years from now. The Roybal bill, while it has some marvelous things, carries with it the baggage of $15 billion, and we do not have that. You know it and I know it.

The Pepper bill, even if you wanted to put everybody into an HMO in the next 3 years—as his bill requires—is $60 billion. Now, that is Star Wars and all the nuclear aircraft carriers and troops home from Japan and Europe all in one bill. And if you think we are going to do that, then you think pigs have wings.

So the idea here of how we are going to divvy up this $15 or $60 billion, which is what I think you are talking to, is so remote. It is a luxury the Chair would love to indulge in. I mean, I would just love to sit and work on grand schemes about how we ought to spend this money more efficiently and whether it is providing relatives with some stipends or whether it is providing professional home health care persons and access.

But right now we have got two problems that I want to talk to the other panel about it. The administration is not doing a thing to spend what they ought to be spending in terms of laws we pass.

Now, as long as I am being critical of the witnesses, let me jump a little on the AARP and damn you by faint praise. You are not doing as good a job as Jimmy Roosevelt in bringing to your membership's attention the benefits of supplemental security income and that ought to make you really upset.

I want to challenge you. I am going to try in my congressional district, and I want you to try it in other congressional districts. And I am going to hand you your lunch. I want to sign up a lot of those people who are entitled to supplemental security income. We have already passed the law for that, and we can end up running Jim Miller and Ronald Reagan very quickly on that and spend what we ought to spend. And, if it is the stigma of welfare attached to SSI, let us call it something else and make it patriotic and pro-Christian and pro-life, or whatever they want to do that will get these folks to sign up for something they are entitled to. And they paid for it; that is what they ought to know. If they obeyed the law and paid taxes, they paid for it. The AARP ought to do more about that instead of trying to beat me and Mr. Gradison on our taxing the actuarial value.

So will you work with me on that?

Mr. **Rother**. Mr. Chairman, I am delighted to accept that, but let me also say that we have not waited for your invitation. We have already been talking with the administration and with the Commonwealth Fund in New York. We are hiring staff now to do just what you have invited us to do; that is, to launch a major campaign of outreach and enrollment, using people in the community who are already there, volunteers as well as professional caregivers, to get people in the program.

Chairman **Stark**. Do me a favor and design into that something that our district offices can do. I have got 25,000 names on my mailing list that I can identify as seniors. You know, maybe I just ought to start a campaign saying each one get one. There are going to be 25,000 people in my district that are entitled that are not receiving it.

Maybe that is too ambitious, but I will bet there are a lot. There are your chapters, and there are all kinds of senior citizens' facilities. There is a Meals on Wheels program. There are a lot of churches with outreach programs.

Mr. ROTHER. Right.

Chairman STARK. I think it needs a little concerted effort, because we are not using the tools we have very efficiently and we should.

Mr. ROTHER. I could not agree with you more.

Chairman STARK. And that is difficult. Getting the administration to do what is right is sort of like trying to push a Doberman Pinscher with a leash. You can pull him but you cannot push him.

Also, Paul, I think we need to be a little more aggressive. The administration tried saving money by kicking people off of Social Security disability. They got such an outcry that finally Congress did something about it. I just do not think, because it is not the individuals that are suffering the initial—they have already been there. Right? They are out of the nursing home or dead, right?

The claim goes by, and so they are going to get a bill later and say, hey, you owe us some money because the claim was denied. Do you bill? I do not know. When a claim is denied, is it your fault?

Mr. WILLGING. When a claim is denied, we may not hold the beneficiary liable.

Chairman STARK. You may not.

Mr. WILLGING. We may not.

Chairman STARK. So the beneficiary is not suffering then?

Mr. WILLGING. Yes, the beneficiary is, but not that individual beneficiary. Because what the nursing home will then do the next time, or the home care agency, will say, hey, wait a minute; this is gray line stuff now. We used to always get this paid by the intermediary, but we are not admitting, we are not visiting that patient because we do not think we will get paid.

Chairman STARK. You are holding back service.

Mr. WILLGING. Absolutely.

Chairman STARK. See, when they took the person off disability, dammit, they did not get the check. I mean, I heard from them the next week or the next day, because that was how they lived.

You present a problem in that this is just like getting brownie points or frequent flyer mileage for these Blue Cross guys. Is that mostly Blue Cross that is doing this?

Mr. WILLGING. The bulk of intermediaries are Blue Cross.

Chairman STARK. Is there 10 across the country now? Is that what they are moving toward?

Ms. HOLLERS. There are 10 fiscal intermediaries for home care.

Mr. WILLGING. That is only for home care. All intermediaries process nursing home claims. There are ten intermediaries regionally who process home care claims.

Chairman STARK. Okay. How many are there that process the whole——

Mr. WILLGING. Forty-five to fifty.

Chairman STARK. Not many.

Mr. WILLGING. Not many.

Chairman **Stark**. Well, I think they ought to know that they tighten up on that at their peril. You do not get mad in this business, but there is sure a lot of fun in getting even.

Mr. **Willging**. We are just trying to become mellow in the nursing home industry.

Chairman **Stark**. Well, that is something we can do right away that will keep us busy while we wait for the budget reconciliation to find out how much we are going to cut here in payments.

I appreciate your being here, and I hope you share our dilemma. We really do welcome anything you can add to this. I wish it did not take all the formality of hearings to bring to light some of the deficiencies in the system, because we do have an oversight responsibility. Perhaps in our anxiety to balance the budget and create new benefits, maybe we are not spending enough time overlooking the benefits that already exist.

I assure you that the interest in this topic is not limited to just this member of the committee, and our attendance here is not indicative at all of the interest in the issues you raise.

I thank you all for taking the trouble to be here. The committee is adjourned.

[Whereupon, at 12:50 p.m., the hearing was adjourned.]

[Submissions for the record follows:]

# WRITTEN STATEMENT FROM THE COMMITTEE ON HEALTH OF THE AMERICAN ACADEMY OF ACTUARIES

submitted to the

SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

April 21, 1987

SUBJECT: Hearing on Long Term Care (Held on March 31, 1987). The following statement is submitted for the printed record of the Hearing.

## I. BACKGROUND ON THE AMERICAN ACADEMY OF ACTUARIES

The American Academy of Actuaries is a professional association of over 8,000 actuaries involved in all areas of specialization within the actuarial profession. Included within the Academy's membership are approximately 85% of the enrolled actuaries certified under the Employee Retirement Income Security Act of 1974 (ERISA), as well as comparable percentages of actuaries specializing in actuarial services for other individual and employee coverages such as life, health and disability programs. As a national organization of actuaries, the Academy is unique in that its members have expertise in all areas of actuarial specialization. Dealing with issues associated with health care financing and insurance is in part the responsibility of the Academy's Committee on Health.

The Academy does not advocate public policy positions which are not actuarial in nature. The Academy views its role in the government relations area as providing information and actuarial analysis to public policy decision-makers, so that policy decisions can be made with informed judgment. It is our belief that the training and experience of Academy members provide for a unique understanding of current practices in insured health care. Our intention is to communicate that understanding in ways that can be of maximum assistance.

It is with this objective that we submit the following comments for your consideration. These comments are confined to a summarization of facts (or estimates) concerning existing private long term care insurance.

## II. EXISTING AVAILABILITY OF PRIVATE LONG TERM CARE INSURANCE TO SENIOR AMERICANS (Those Eligible for Medicare)

There is a general impression, reinforced by recent televised programs on the subject broadcast by national media, that private long term care insurance is virtually non-existent and generally unavailable to senior Americans.

Such is not the case. Private individual insurance for long term nursing care is widely available, and has been since about 1980. There are at least a dozen major insurers offering this insurance; most of them offering such coverage multi-state. Several of these insurers are currently selling such insurance to senior Americans in large volume and with few underwriting restrictions. Long term care coverage under Group policies is also increasing rapidly.

The benefits are generally quite extensive, and most such plans provide coverage of truly catastrophic scope. Coverage extends to intermediate and custodial nursing care, as well as skilled care. A number of plans also provide home care coverage. Usually benefits are provided on a fixed dollar daily basis up to as high as $50 daily; under a few plans, to as high as $100 daily. For prolonged confinement, most such plans provide coverage up to at least a year; some for as long as five years or even longer.

Some of these plans are sold as optional benefits added to Medicare Supplement insurance policies. Many plans, however, are available as separate Long Term

Nursing Care policies. They are all widely available to the public, not only to those of age 65 or higher, but usually to persons age 50 or higher and in a few cases at any age.

## III. EXISTING STATE REQUIREMENTS RELATING TO LONG TERM CARE INSURANCE

A number of states have enacted laws or regulations requiring that Long Term Care policies or benefits must be offered by all insurers selling Medicare Supplement insurance in the state, or in some cases by all insurers selling any form of hospital/medical insurance in the state. Examples are Kentucky, Minnesota, South Dakota and Wisconsin. Where such requirements exist, minimum benefit standards are also prescribed.

The National Association of Insurance Commissioners has also been in the process of developing minimum benefit standards for Long Term Care insurance.

## IV. RECOMMENDED PRINCIPLES WITH RESPECT TO POSSIBLE FEDERAL STANDARDS FOR LONG TERM CARE INSURANCE

In anticipation of the likelihood that Federal minimum standards for Long Term Care insurance will soon be developed and promulgated, we respectfully propose for your consideration four basic principles that we believe are important if such standards are to address the problems and peculiarities of this type of insurance successfully:

1. The first of the four principles that we urge your Subcommittee to consider carefully is that recommendations as to minimum benefit guidelines should not be too broad or too rigid. Long term care insurance is a relatively recent development. Little is known thus far as to its actuarial cost. Further, increasing availability of such coverage will inevitably have an upward impact on its cost, since it will increase utilization of the care that is being insured.

Private insurers need opportunity to experiment with plan design, as to soundness and marketability, and to learn how to underwrite and price such coverage soundly, before being pushed too quickly into broad benefit provisions that could turn out to be underpriced; or too quickly into rigid standards that would limit experimentation and even have the result that the potentially most successful plan designs, from the perspective of serving public need at reasonable cost, could be overlooked and excluded entirely.

One benefit design guideline that should not be too restricted is the use of front end deductible periods. Relatively long deductible periods, such as the first 100 days of nursing facility confinement, are already in use, and we would suggest that even longer periods, such as 180 or 365 days, can be appropriate. No other single plan design item is more effective in making valuable protection available at reasonable cost than the use of substantial deductible periods. The public tends to WANT immediate first-dollar coverage. But what is usually the most NEEDED is protection against the cost of extended long-term care. Substantial deductibles can bring this coverage within the range of affordability of the average person.

On the other hand, guidelines should also not establish minimum coverage periods that are too ambitious, at least at the outset, because uncertainty of the cost of long coverage periods could get insurers into financial difficulty very quickly. Guidelines need to allow adequate flexibility for experimentation.

2. Secondly, we urge that underwriting standards not be too limited. Long term care insurance, more than almost any other kind of insurance, is potentially subject to enormous antiselection by buyers who expect to use the benefits. Private insurers must be allowed to apply sound underwriting selection, or buyer antiselection of this coverage could easily drive costs out of control. This has already been the result for some insurers.

The ultimate goal, of course, is to render such coverage available to as broad a segment of the public as possible, but excessive limitation on underwriting freedom could drive the cost too high with self-defeatig results and even failure of the entire concept.

3. Thirdly, we would urge that guidelines for measuring reasonableness of

premiums should not be too demanding. Since the cost of this coverage is little known, insurers will need reasonable risk margins. Pricing guidelines, such as minimum loss ratio requirements, that are too demanding will serve to discourage insurers from entering this field of health insurance.

4. Lastly, we urge that price structures providing for advance funding of future costs be encouraged. An example of this is "level" premiums determined on the basis of entry or issue age. Recent state regulatory restrictions on the pricing of health insurance have tended to force premiums more and more toward very short term funding, such as one year term. The result of this shortsighted regulatory policy is that subsequent rate increases become maximized, encouraging antiselect lapsation among healthier insureds. This leads to steady deterioration of the average health of the continuing body of insured individuals and the cost spiral is further accelerated.

Further, it would be desirable that persons in mid-life (between the ages of 50 and 64) have opportunity and encouragement to purchase this coverage on a basis where the costs of the elderly years can be at least partly prefunded. Americans in the 50-64 age bracket have, relatively, the largest amount of discretionary income and are in the best position to prefund the costs of long-term care in the senior years. They should be given definite incentive to do this.

Our Committee would be pleased to answer questions or provide further input as your Subcommittee might desire.

Respectfully submitted,

American Academy of Actuaries Committee on Health, by

E. Paul Barnhart

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# STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION ON LONG-TERM CARE

Submitted to the
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

April 17, 1987

## SUMMARY

Three misperceptions tend to dominate thinking about long-term care:

- That long-term care is exclusively a problem for the elderly. Although age is an important determinant, long-term care needs are a function of both physical and psychological disabilities that impair daily functioning at any age.
- That long-term care is equivalent to nursing home care. Most long-term care (70 percent) is provided at home and in the community, not in nursing homes, and entails not only skilled care but also assistance in the activities of daily living.
- That long-term care is paid primarily by public funds through Medicare and Medicaid. Nearly half of all nursing home costs, which account for almost one-third of long term care costs, are paid out-of-pocket by recipients or their families. Most of the public funding for nursing home services comes from Medicaid, which pays for about 45 percent of nursing home expenses.

Long-term care has become a pressing public policy problem because the costs associated with long-term care are enormous, the need for long-term care is likely to grow, and current reliance on the Medicaid program for long-term care for the elderly is straining that program's ability to provide acute services for the poor.

In the short term, the American Hospital Association (AHA) recommends closing the gaps in Medicare coverage to make extended-care services more accessible to beneficiaries. Specifically, Congress should:

- Require that the coverage criteria used by Medicare fiscal intermediaries be written and available to beneficiaries and providers;
- Relax the intermittent and home bound requirements for home health coverage and the conditions for waiver of the prior hospitalization rule for access to extended care services in skilled nursing facilities;
- Provide community based waivers under Medicare to experiment with the provision of non-hospital services, including social services, in case-managed programs using community services;
- Where post-hospital extended-care services are not available, allow hospitals to furnish services and be paid at the appropriate rate;
- Detach the Skilled Nursing Facility (SNF) copayment from the hospital inpatient deductible so that Medicare pays a fair share for covered skilled nursing stays;
- Eliminate the 190-day limit for inpatient psychiatric hospital services; and
- Conduct a study on potential modification of the 2-year waiting period for disability coverage for the permanently disabled.

In addition, the AHA recommends as an alternative to the "spend down" requirements for Medicaid eligibility a system of federal and state loans, guaranteed by an individual's estate, to allow spouses or dependents of individuals in nursing homes to qualify for public assistance by pledging a percentage of their assets. The spouse or dependent would continue to enjoy the use of property and investment income until he died or decided to liquidate the estate.

In the long term, AHA recommends a system combined of private and public funding that encourages individuals to provide for their own long-term care as much as possible, and provides access to needed long-term care when individual resources are inadequate. Such a program should be flexible in financing to encourage innovations in delivery, including case management to assure continuity of care.

In recognition of the fact that Medicaid has become a program of supplemental long-term care insurance for the elderly, the AHA recommends restructuring the Medicaid program into three distinct parts:

- A program of acute care coverage for the poor;
- A program to purchase supplemental acute coverage for the low-income elderly and disabled under Medicare Part B; and
- A program of long-term care insurance, funded by either the states or a combination of state and federal appropriations.

## INTRODUCTION

The American Hospital Association, on behalf of its 5,600 institutional and over 40,000 personal members, welcomes this opportunity to submit comments on the issue of long-term care. The AHA commends the subcommittee for addressing this critical issue. With all the attention now placed on protections for catastrophic acute care, it is particularly important to consider the catastrophic needs of the chronically ill and disabled.

## THE NATURE OF LONG-TERM CARE

It is important when thinking about long-term care to overcome three common misperceptions.

Long-term care is not exclusively a problem for the elderly. Although age is an important determinant, long-term care is a function of both physical and psychological disabilities that impair daily functioning, so the population at risk for catastrophic long-term care expenses includes both the elderly and non-elderly chronically sick and disabled, as well as the developmentally disabled and chronically mentally ill.

Long-term care is not equivalent to nursing home care. Although our public policies have tended to focus funding and delivery of long-term care on inpatient institutional care, 70 percent of all long-term care is provided at home or in the community and entails not only skilled care but also assistance in the activities of daily living--personal and social services like assistance with eating, walking, or bathing, as well as shopping, meal preparation, and housekeeping. Because long-term care is by definition a response to social and psychological needs, any attempt to address long-term care without accomodating the need for social and psychological services would be sorely deficient. The availability of these non-medical services often can mean the difference between maintenance in the community and much costlier institutionalization.

Only a small proportion of long-term care is paid by public funds. As noted above, most long-term care is non-institutional, while public programs have focused their financing on the provision of nursing home care. Furthermore, nearly half of nursing home costs are paid out-of-pocket by recipients or their families. Most of the public funding for institutional long-term care services comes from Medicaid, which pays for about 45 percent of nursing home expenses. Medicare's acute care orientation has rendered it a limited factor in the provision of long-term care. Medicare pays for less than 2 percent of nursing home costs and nothing for such long-term care services as adult day care, emergency response, homemaker services, or special services required for Alzheimer's disease patients.

Hospitals have increasingly become involved in the provision of long-term care services. In 1986, 40 percent of community hospitals provided extended care through hospital-owned or -operated skilled nursing facilities, swing beds, intermediate care facilities, or psychiatric long-term care facilities. Understandably, the most rapid growth in recent years has been in the development of skilled nursing facilities and home health services, the more intensive and medically oriented long-term care services. Between 1983 and

1985, the percentage of community hospitals owning home heatlh agencies doubled, from 15.5 percent to 33.3 percent; hospital ownership of SNFs grew during that time by 50 percent, from 15.4 percent to 22.6 percent. But hospitals also provide, in increasing amounts, day hospital care, rehabilitation, adult day care, and hospice services.

## THE PROBLEM OF LONG-TERM CARE

Long-term care has become a pressing public policy problem because the costs associated with long-term care are enormous, the need for long-term care is likely to grow, and current reliance on the Medicaid program for long-term care for the elderly is straining its ability to provide acute services for the poor.

Long-term care is the leading cause of catastrophic health care expense. Nearly half of all institutional long-term care expenses are privately paid, accounting for slightly over 40 percent of all personal expenditures for health care. Medicare provides only limited coverage for post-acute skilled nursing care, and no coverage for intermediate care or custodial home health care. As a result, almost half of the 75-year-olds who enter private nursing homes are bankrupt in 13 weeks, and more than 70 percent exhaust their resources after a year. Medicaid covers extended care at the skilled nursing, intermediate, and custodial levels, but to qualify for Medicaid coverage it is necessary to "spend down" savings and investments, including investments in a family home, impoverishing the non-institutionalized spouse or dependent and pushing more people into public dependency.

Several demographic trends are likely to increase the need for long-term care. Life expectancy has dramatically increased, so the proportion of the population over 65, and particularly those over 75 who are most at risk for long-term care expenses, is growing rapidly. As people are less likely to be stricken by fatal acute diseases, they are more likely to fall victim late in life to debilitating or disabling conditions. Moreover, an increasing number of the old will be unable to depend on family to provide long-term care services. More women working, later marriages, fewer children, more divorces, and greater geographic mobility--these are familiar trends which, given the current predominance of family support in the provision of long-term care today, mean an inevitable change in the provision of this care in the future. Over the next 50 years, the National Center for Health Statistics projects that the nursing home population will increase more than threefold, from 1.5 million to 5.2 million residents.

Finally, the use of Medicaid as the principal third party payer for long-term care has absorbed a large proportion of Medicaid funds and put considerable strain on the funds available to support the non-Medicare poverty population. Currently, about three-fourths of all Medicaid expenditures are used to pay long-term care costs and other expenses generated by Medicare enrollees, leaving about one fourth for the growing number of non-elderly, non-disabled poor. The large and growing number of uninsured results, in part, from an increase in the number of people below the federal poverty level; but it also stems from a simultaneous decrease, due to eligibility restrictions, in the number of people covered by Medicaid. By 1983, Medicaid covered fewer than 40 percent of the poor, compared with 65 percent in 1976.

There are problems with access to two distinct types of long-term care services: access to adequate extended care services associated with episodes of acute illness; and what is more conventionally thought of as long-term care--the maintenance of individuals with stable but chronic conditions. Using the current array of services available under Medicare and Medicaid, there are ways to enhance access to extended care services under Medicare and prevent the pauperization of the elderly seeking nursing home coverage under Medicaid. But for long-term solutions to the problems of the chronically ill and disabled, it will be necessary to undertake a major restructuring of Medicare and Medicaid, including the creation of a separate public program for long-term care to supplement private financing mechanisms.

## SHORT TERM IMPROVEMENTS

Short of a total reorientation of the Medicare and Medicaid programs, there are several ways that existing programs could be modified to reduce some of the inadequacies of our current system for providing extended- and long-term care services. The Medicare benefit should be restructured and administration improved to make extended care services more available for the elderly. In addition, for those who must use their own resources to cover large long-term care expenditures, we suggest an alternative to prevent the impoverishment of spouses and families under current "spend down" provisions.

### Gaps in Medicare Coverage

Most Medicare enrollees purchase supplemental or "wrap-around" coverage, some with the mistaken expectation that it protects them against long-term care costs. However, because the benefits of "wrap-around" coverage are generally limited to services covered by Medicare, even with these policies most Medicare enrollees have almost no protection against long-term care costs.

There are several problems that restrict Medicare's usefulness for extended care services. First, Medicare has arbitrarily limited the definitions of covered skilled facility and home health services to restrict access to payment. Strict interpretations of what constitutes "skilled" care or, for rehabilitation patients, "rehabilitation potential," have led to the retroactive denial of many patient days in skilled facilities. Although Medicare offers 100 days in a skilled nursing facility, the average Medicare coverage of a skilled nursing stay is a mere 27 days. At the same time, narrow interpretations of the "intermittent" care requirement for home health coverage under Medicare has tended to disqualify those with more intensive skilled nursing needs. Thus, a patient may need too little "skilled" care to qualify for SNF placement, but too much to get access to home health benefits. It is important that the fiscal intermediaries be required to write their coverage criteria and make them available to providers and beneficiaries. This will promote understanding of the benefit and improve the assessments by all parties of the appropriateness of SNF and home health claim denials.

Making sense out of the coverage criteria for these services also should focus on sorting out where beneficiaries should be cared for when they have an acute episode and provide sufficient flexibility to use the appropriate level of services without arbitrary barriers. The original Medicare benefit was designed with the expectation that most acute care would occur in inpatient hospital settings. This is no longer true. To recognize the changes that have taken place in health care delivery, it will be necessary to relax the intermittent and home-bound requirements for home health, and eliminate, in whole or in part, the three-day prior hospitalization rule for SNF coverage.

For example, it has been suggested that the intermittent care restriction be redefined to allow for intensive skilled nursing or physical therapy, e.g., up to two visits a day for a limited number of days. In addition, Congress should reconsider the budgetary restrictions attached to the Secretary's authority in Sec. 1812(f) of the Social Security Act to waive the prior hospitilization rule for extended care. Finally, although the current focus on "skilled" care prohibits coverage of services for assistance with the "activities of daily living" (walking, eating) and the "instrumental activities of daily living" (shopping, preparing food), it has been demonstrated that appropriately managed community based services can prevent costly institutionalizations. In California, case-managed community based services have demonstrated costs about 70 percent of those in institutions. The AHA recommends providing community based waivers under Medicare like those now available under Medicaid, where, with the use of case management, it can be cost effective to provide community based services in place of institutional care. These changes could enhance the use of the Medicare benefit for post-acute extended care without exposing the program to unlimited liability, and without violating its essential nature as an acute care benefit.

As a consequence of what are perceived to be stringent, often arbitrary, and highly variable interpretations of the coverage rules, SNFs are often reluctant to accept Medicare patients, which impedes transfers from acute to less intensive settings and inhibits access to the SNF benefit. Furthermore, while the need for post-acute institutional care has been increasing, state governments, perhaps to limit their own liability under their Medicaid programs, have limited growth in the number of nursing home beds. Six states have imposed moratoria on the addition of new beds. Medicare needs to eliminate arbitrary barriers to the provision of needed skilled subacute services by hospitals. Where extended care services are needed but appropriate placement is unavailable, hospitals should be able to provide the services and be paid for them at the appropriate (i.e., skilled) rate.

The current structure of the copayment for SNF services has also become an obstacle to services under Medicare. Because the copayment is tied to the hospital inpatient deductible, which has risen dramatically over the past few years, over 90 percent of the daily cost must be paid by the beneficiary after the 20th day in a skilled nursing facility. This copayment needs to be separated from the inpatient hospital deductible so that it serves the desired purpose of controlling excess demand while still providing a fair contribution by the Medicare program to the cost of extended care.

Medicare provides extremely limited coverage of psychiatric services and insufficient coverage for the rehabilitation of stroke or accident victims. It is time to eliminate the 190-day limit for inpatient psychiatric hospital services as no longer necessary. With extensive utilization controls and cost-per-case limits on payment, there is no basis for perpetuating a two-class system of coverage for psychiatric and non-psychiatric illness. It is inappropriate to substitute a limitation on benefits for effective utilization review.

Finally, we believe it is time for Congress to reexamine the two-year waiting period for disability coverage under Medicare. For the permanently disabled, the two-year wait can cause severe hardship and discontinuity of care. Recognizing the potential cost of totally eliminating the waiting period, we recommend that a study be conducted of incremental modifications that could be made.

## Subsidized Loans as an Alternative to "Spend Down" Requirements

Some individuals admitted to nursing homes return to their homes after a limited stay; others remain in the nursing home until death. If those individuals who are able to return to the community have been impoverished by the spend-down provisions, they are likelier to become permanent residents of long-term care institutions, at considerable cost to the public. Furthermore, when nursing home patients with non-institutionalized dependents are compelled to sell homes and consume income-producing investments, public assistance costs and nursing home admissions can increase. Moreover, the standard of living for dependents may be reduced to an indecent level. When an individual without dependents is admitted to a long-term care facility with little expectation of returning to the community, it may not be inapproppropriate for him to use his savings to support it. The challenge is to develop a way of enabling individuals to draw on their resources that will not prevent them from returning to the community or force their families into public dependency.

As an alternative to the "spend down" requirements for Medicaid eligibility, a system of federal and state loans, guaranteed by an individual's estate, would allow spouses or dependents of individuals in long-term care facilities at any level (skilled nursing, intermediate, or custodial care) to qualify for public assistance by pledging their assets, or a percentage of their assets. The spouse or dependent would continue to enjoy the use of real property and the income generated by investments until he (or she) died or decided to liquidate the estate because he (or she) had entered a long-term care facility and had little expectation of returning to the community. Rather than spending down to meet an eligibility test, beneficiaries using this option could be required to meet annual cost-sharing requirements which could be tied to their annual income. This alternative is not without problems--e.g., in converting the real property posted as collateral into cash--but may be a viable and more humane alternative for Medicare beneficiaries.

## LONG TERM GOALS OF PUBLIC POLICY

The financing of long-term care is likely to continue to be a shared responsibility of individuals, the private sector, and state and federal government. The AHA suggests three general propositions for a combined public and private strategy to provide for coverage of long-term care.

First, public policy should encourage individuals to provide for their own long-term care to the extent permitted by their income and, to the extent necessary, provide access to needed long-term care when individual resources are inadequate. Such a strategy would have to consider whether individuals should be required to spend their lifetime savings to pay for long-term care, or whether their estates should be protected. It may be necessary to distinguish between those individuals who were unable to make provision for long-term care needs, those who could have but chose not to, and those who sheltered their assets by giving them away to their heirs.

Second, the current institutional and medical bias for financing long-term care should be reconsidered. The non-institutional alternatives, including social and personal services as well as skilled care, can potentially provide superior care at lower cost. But, perhaps more important, the kind of long-term care provided will depend on the array of services available in the community. Some flexibility is needed in the financing of long-term care that will ensure access to needed services and encourage innovation in service delivery.

Finally, it is essential to consider case managment or some other systematic coordination of services, to combat the fragmentation that currently characterizes the provision of long-term care and to assure the continuity of care among service providers.

Private Long-Term Care Insurance

Several proposals have called for federal incentives to encourage private sector financing of long-term care to relieve the pressure on public programs. The development of private sector alternatives for financing long-term care can be encouraged through tax incentives as well as public and private demonstration projects. These initiatives should include efforts to increase understanding among the elderly and non-elderly of the inadequacies of current coverage of long-term care and the risk of needing long-term care.

Individual Medical Accounts (IMAs) have been suggested for self-insurance of long-term care. Although IMAs might provide a vehicle for financing a part of the care needed by future Medicare beneficiaries, they cannot form the principal source of funding, because they are likely to be used predominantly by upper income groups and because they do not entail any sharing of risk, which is essential to ensure adequate coverage and affordability of contributions.

The difficulties of privately insuring long-term care should not be underestimated. The major barrier to private long-term care insurance is the extreme uncertainty surrounding whether services will be needed, and the high costs of services if they are needed. Pre-funding mechanisms, such as the IMA, also must contend with the uncertainties caused by fluctuations in the rate of inflation, in the cost of long-term care, changes in life expectancy, changes in the incidence and prevalence of chronic diseases, and changes in delivery patterns for long-term care services. These uncertainties require some form of risk pooling over relatively large populations, suggesting that some involvement of government in the financing of long-term care may be necessary. Although commercial insurance companies have begun to enter the long-term care market, such insurance is still viewed as experimental. Their coverage tends to be narrow, focusing typically on nursing home care, and shallow, tending to cover only shorter stays (such as 3 months). As with all private insurance options, the coverage offered will tend to be limited to control risk, so many of the neediest will find such coverage unavailable.

There is a significant marketing problem for private long-term care insurance in that people generally do not understand the limits or nature of Medicare coverage. Most beneficiaries believe that their long-term care needs will be covered by Medicare. It is essential that the Medicare benefit and coverage be simple and clearly stated so that beneficiaries can understand the gaps in their coverage. Greater simplicity in the determinations of beneficiary copayments would also improve the ability of beneficiaries to assess their need for and the adequacy of private supplemental coverage.

Public Financing of Long-Term Care

Private long-term insurance and other private sector financing methods will reduce the need for public financing, but will not eliminate the need for public programs. Public and private initiatives address the needs of different populations.

Last year, the AHA's Special Committee on Care for the Medically Indigent, in examining the problem of medical indigence, found that the Medicaid program has drifted away from its original focus on acute care for the non-elderly poor, and has become instead a supplemental program of Medicare Part B buy-in and nursing home insurance for the elderly. In order to more clearly address the three separate needs that Medicaid has come to support, the AHA recommends dividing the program into three parts:

- Acute medical care coverage for the uninsured who are not eligible for benefits under Medicare--what we now perceive as Medicaid;
- A program to purchase supplemental Medicare Part B coverage for the low-income Medicare-eligible population. This program, which would round out the acute care insurance coverage of the Medicare beneficiary, would be funded out of general revenues of the federal government, and would simply involve the transfer of funds to the supplemental insurance trust fund;
- A program of long-term care insurance, funded by either the states or a combination of state and federal appropriations. This program would replace part of the current Medicaid program, would be designed to be compatible with emerging approaches to the private funding of long-term care, and would address the problems of the low-income Medicare patient unable to obtain private insurance or pay for long-term care out of savings.

In recommending this restructuring, the AHA recognizes the importance of the issue of long-term care, but acknowledges the limitations of current methods of delivery and financing. The AHA believes that better approaches need to be developed, and that by setting up a program devoted exclusively to long-term care, the search for innovative approaches such as case management or capitation may be encouraged.

## CONCLUSION

It is clear that long-term care is destined to be a significant health care policy issue. Current public programs do not adequately meet long-term care needs, and with Medicare's limitations on extended care coverage, and Medicaid's emphasis on nursing home care, do not assure access to community services and do not encourage innovation in service delivery. In the short term, much can be done to enhance access to extended care through Medicare, and steps can be taken to prevent the impoverishment of the spouses and dependents of individuals who must now spend all their resources to become eligible for Medicaid coverage of nursing home care.

In the long term, public policy should encourage the private financing of long-term care services, in a flexible way that encourages the use of community resources. Although still experimental, private long-term care insurance shows promise. Nevertheless, there will continue to be a need for a residual public program of long-term care insurance for those with limited resources. A separate program to fund long-term care would relieve the current strain on provision of acute coverage to the poor under Medicaid, and could be structured to encourage innovative, community based services for the chronically ill and disabled.

LEGISLATIVE MEMORANDUM

CancerCare, Inc.
and the National Cancer Care Foundation, Inc.

Werner Weinstock
Chairman, Public Affairs Committee

Jan C. Childress
Vice Chairman, Public Affairs Committee

Doris B. Nash
Public Affairs Director

April 8, 1987

To: Honorable Fortney H. Stark, Chairman
Subcommittee on Health
Committee on Ways & Means
U. S. House of Representatives

Re: Catastrophic Coverage Under Medicare

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Susan T. Vandiver, A.C.S.W.
Acting Executive Director

We are pleased at this opportunity to present written testimony on the issue of catastrophic coverage under Medicare, and the necessity for ample home care benefits.

Cancer Care, Inc. is a voluntary social service agency which, for over 42 years, has offered comprehensive social services to cancer patients and their families. We have offices in New York City, Long Island and New Jersey and we are completely dependent upon contributions from the public and foundations. Our services include individual and group counseling, help with planning for the care of the patient, as well as some financial assistance to eligible families to help them meet the costs of home care plans and transportation to and from radiation or chemotherapy. We are also utilizing a special foundation grant in 3 boroughs of New York City to assist certain medically indigent patients with payments for cancer therapies. During our '85-'86 year, we served over 10,000 patients and disbursed more than $990,000, with most of the disbursements going to elderly patients. In the first 7 months of our current fiscal year we have assisted over 6300 patients and have disbursed nearly $640,000.

Since we deal on a daily basis with the dread and very often catastrophic illness of cancer, we are extremely knowledgeable about the many needs of these patients and the financial, practical, and emotional problems which confront them and their families. We feel that this expertise is translatable to other catastrophic illnesses which also frequently require a multitude of out-patient services.

Many years ago our agency did a study of the illness-related costs experienced by many of its patients. We found then (1972) that the median cost was $19,054, while the median health insurance payments these families received were only $8,000. True, our definition of illness-related costs is a broad one. We include in our calculations all the special needs that are sparked by the patient's illness. Paramount among these are home health care, child care, housekeeping costs, transportation, and medication. While our definition may be broad, it is very realistic — the cost of illness cannot be measured just by hospital and physician charges.

A 1984 study of a sample of 404 of our patients reconfirmed that so many of the patients'/families' expenditures were related to out-patient costs. We were giving some financial assistance to over 1/3 of these patients and 26 percent of the patients had depleted 80 to 100 percent of their assests. Ninety of the patients reported that their monthly expenses had increased 40 to 79 percent as a result of the illness. The major reasons for these increases were special living costs due to the illness and out-patient medical costs.

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For those with seemingly adequate health insurance coverage, an illness can still cause a catastrophe because of the "hidden" costs created by the illness. Thomas Hodgson, in an article on "Social and Economic Implications of Cancer in the United States" (Annals of the New York Academy of Science, Vol. 363, 1981), speaks to the need to study non-health sector direct costs, which he estimates may add another 5 to 25 percent to the total direct costs. The non-health sector direct costs he refers to are special diets and clothing, dwelling modifications, homemaker care.

Also, according to the NMCES study conducted by the National Center for Health Services Research and completed in September 1979, "A fifth of the nation's 80 million families incure catastrophic out-of-pocket medical expenses - costs that absorb an abnormally high percentage of their total income." (NCHSR Research Activities, May 1986, No. 85). Clearly the problem is very prevalent.

Our lengthy experience confirms that for the majority of cancer patients, inpatient care in a hospital is relatively minimal in comparison to the out-patient needs that are sparked by the illness. Therefore, we have long questioned the adequacy of any catastrophic coverage plan that is based merely on more comprehensive coverage for inpatient care. As a result, we have been critical of the President's and other proposals to ensure that Medicare patients will not be required to spend more than $2,000 a year for deductibles and co-insurance payments for hospital care.

For the great majority of the elderly, the cost of inpatient hospital care is the least of their worries, since most hospitalizations are short term and are covered by Medicare. While it is estimated that more than 200,000 elderly Americans each year experience hospital stays in excess of 60 days, this is indeed a very small segment of the many millions enrolled in Medicare — 29,284,396 as of February 1986. Further, the average length of hospital stays for patients over age 65 was only 8.9 days in 1984. Clearly the overwhelming majority of Medicare patients experience only short hospital stays.

While we certainly sympathize with the plight of those Medicare patients whose hospital stays exceed 60 days, or those who may need several hospitalizations in one year, singling them out for increased benefits does not compensate sufficiently for the other inadquacies in Medicare coverage. We must be just as concerned with those who are forced to spend great sums of money — sometimes pauperizing themselves — to secure adequate and sufficient home care services.

We must also be concerned with how much Medicare patients must spend for drugs. And, can we dare overlook Medicare's very inadequate coverage for long-term care — how to pay for nursing home care justifiably worries Medicare patients a great deal.

A very prolonged hospital stay is far from being the only definition of catastrophic illness. The definition must be broadened to include those illnesses which require extensive home or institutional care. These patients also deserve to be helped to acquire these services with dignity and without fear of impoverization. Unfortunately, your proposals, H.R. 1280 and H.R. 1281, do not expand in any way Medicare's current home health benefits and regulations.

We feel compelled to take this opportunity also to point out that while there has been a swing towards amending Medicare to completely cover hospital care, the DRG reimbursement system, designed to decrease health care costs, has led to earlier discharges from hospitals. Medicare patients are being sent home earlier in their illnesses than ever before. Simultaneously there have been cutbacks in the availability and intensity of Medicare's home health services. This has been accomplished by reinterpretations of the Medicare statute and the creation of new definitions.

We have long criticized Medicare because of its paucity of coverage for out-patient needs, and its stringent eligibility requirements for home health care: the patient must require a skilled service, must not need more than part-time or intermittent care and, in most instances, the patient's condition must be acute and short term. These rules governing home health care always eliminated a very large number of elderly cancer patients who may need daily care from a home health aide for a more protracted period of time, or, may not need a skilled service at home in the first place.

Now, because of the new rules and regulations governing Medicare's home health services, even fewer patients are receiving assistance at home. This is a situation that must be addressed quickly, and we are pleased that Representative Staggers and 13 other Congressmen have joined in a suit against the Department of Health and Human Services, challenging "the attempted dismantling of the Medicare home health benefit via actions which are violating plantiff's rights under the Medicare statute, the Administrative Procedure Act and The United States Constitution." We are hopeful that this suit will at least restore Medicare's home health services program.

Any plan for coverage of catastrophic illness is incomplete unless it includes sufficient coverage for the care-at-home needs of patients. We can and do appreciate the possibility that opening up and broadening the home health benefit will sharply increase Medicare's expenditures for home health care. We can also appreciate that eligibility criteria would have to be carefully worked out and that adequate case management would be essential. But we must remember that ignoring the problem doesn't necessarily mean that government gets off the hook entirely.

Elderly patients who need long term home health services frequently end up depleting their resources, actually pauperizing themselves. This is called "spending-down" in the language of Medicaid, the federal-state health care program for the very poor. The patient's care is then paid for by the government, at least in those states such as New York that have spend-down programs. Other elderly folk, having caught on to the system, turn their resources over to their children so as to be eligible for Medicaid in advance of their actual need for care. Thus, in many instances, government ends up paying for out-patient care, including home care, just as it does for the nursing home care of millions who may have started out by paying for this care themselves. Shouldn't government be willing to help the elderly with their realistic home care needs in such a way as to avoid reducing them to poverty or duplicity?

In closing, we want to reiterate our belief that **adequate coverage for home care must be an integral part of any catastrophic health insurance plan.** Only then can a catastrophic plan be truly meaningful.

Statement of

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Research Associate

The views expressed in this statement are solely those of the author and they should not be attributed to the Employee Benefit Research Institute, its officers, trustees, sponsors, or other staff.

# THE FEASIBILITY OF EMPLOYER-PROVIDED LONG-TERM CARE INSURANCE

## Introduction*

The development of a market for private long-term care insurance offers the potential to pool risk and reduce public expenditures for long-term care. To realize this potential, the number of covered persons must represent a broad portion of the population. One way to ensure that a broad spectrum of people have long-term care insurance is to encourage employers to provide the insurance as an employee benefit.

Employer-provided benefits such as pensions and health insurance have proven effective at providing active workers health insurance and retirees retirement income security in the form of pensions and post-retirement medical benefits. Without these benefits the rate of health insurance coverage would probably be far less and the economic security of many retired persons would be substantially more uncertain.

The development of a private insurance market for long-term care has been hindered by conceptual problems and a lack of information that affects both supply and demand. Actuarial data to estimate risk, costs and predict consumer behavior are not readily available. Public (and public-sector) reluctance to acknowledge the cost of long-term care, as well as widespread misinformation about existing Medicare coverage for long-term care, have also contributed to the absence of private or public financing.

Over the past five years, however, private insurer interest in marketing coverage for long-term care has grown. Most major health insurers are now either marketing or testing a long-term care product. One recent survey of insurance trade association members indicates that at least 13 insurers are currently selling long-term care policies of some type, and another 15 expect to do so this year (HIAA, 1986). Estimates of the market place the number of insurers at 60, with about 200,000 policies written (Lane, 1986).

The long-term care insurance market is currently dominated by individual products marketed primarily to the elderly. Long-term care insurance products are almost without exception indemnity plans that pay a fixed dollar amount per day for each day spent in a nursing home or for each day of home health care. Policies commonly require a waiting period to qualify for benefits and a hospitalization to trigger benefits. Indemnity amounts are generally not indexed for inflation, and benefits may be limited to three or four years.

These types of insurance products reflect insurers' considerable concern about moral hazard. The potential insurer cost resulting from informal caregivers substituting formal, covered services is substantial, although experience from other countries suggest that relatively little substitution might in fact occur. Countries that have added long-term care coverage to their national health insurance, have seen minimal substitution of formal for informal care (Kane and Kane, 1985; Kane, 1986). Nevertheless, U.S. insurers have focused on limiting their exposure by offering unindexed indemnity plans that pay benefits only after hospitalization, and then for a limited (although generally sufficient) period of time.

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*This statement summarizes Deborah J. Chollet and Robert B. Friedland, "Employer Financing of Long-Term Care," in Advances in Health Economics and Health Services Research, Richard M. Scheffler and Louis F. Rossiter (eds.) JAI Press. Charles Betley of EBRI provided invaluable research and programming assistance.

The pricing of these first-generation insurance products reflects the fact that they are marketed primarily to retirees or people who are close to retirement age, and marketed as individual (rather than group) products. Premiums are high, reflecting the greater imminent risk of long-term care need among an older population. Coverage sold to a younger population would offer the opportunity to average individual risk over a longer period of years, reducing the present value of expected long-term care cost and, therefore, the annual premium. This is the premise of whole or universal life insurance, compared to term insurance for that risk.

The sale of long-term care insurance to individuals rather than groups also contributes to its cost. A group product reduces the likelihood of adverse selection and lowers marketing costs; it may also broaden the risk pool to include younger, healthier populations' subsidizing the current cost of older participants. Economies of scale in the administration of group insurance may also reduce cost. The advantages of marketing to groups, and insurers' experience with employer group products, make employers an obvious target for a group long-term care insurance product. Nevertheless, very few employer group products have been developed.

## Employers and Income Security in Retirement

The role of employers in assuring retirement income security is substantial. In 1984, 34 percent of people over age 65 reported income from a pension. Among higher-income elderly (those with family income at twice the poverty level or more), 43 percent reported pension income. For a significant number of elderly, private and public pension plans provide a substantial portion of their total retirement income. Among elderly couples and individuals reporting private pension income in 1984, 47 percent received 20 percent or more of their total income from one or more private pensions; 12 percent received half or more of their total income from private pensions. Public pensions (which commonly are automatically indexed after retirement) are an even more important source of income among elderly recipients. In 1984, 75 percent of elderly couples and individuals reporting public pension income derived 20 percent or more of their total income from public pensions, and 35 percent reported half or more of their total income from public pensions (Grad, 1985).

More than half of workers age 25 to 64 participate in an employer-based pension plan. Although the rate of pension plan participation among workers is several points lower than before the economic recession of the early 1980s (52 percent in 1985, compared to nearly 56 percent in 1979), employer-based pension plans are expected to remain important as an employee benefit and source of retirement income among future retirees (Chollet, forthcoming).

Employer-sponsored health insurance benefits for retirees have also become an important and fairly common employee benefit. In 1985, 84 percent of private sector workers in medium and large establishments in the United States (generally establishments that employ 250 workers or more) had health insurance plans that continued benefits after retirement at age 65.[1] Although many employers may have initiated retiree health benefits rather casually, as a presumed low-cost alternative to enhanced pension benefits, retiree health plans now provide a valuable real retirement income supplement. For low-income retirees, the value of their retiree health benefits (automatically indexed to the rising cost of health care) can exceed the amount of their pension benefit over time.

Among current retirees age 65 or over, at least 24 percent have health insurance benefits from a past employer to supplement Medicare (See Table 1). Although retiree health insurance benefits are more common among pension recipients, a significant number of elderly without pension income also report health insurance benefits from a past employer.

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[1] EBRI tabulation of the 1985 Employee Benefit Survey (U.S. Department of Labor, Bureau of Labor Statistics).

The success of employer pension plans in facilitating retirement saving, as well as employers' established position in financing health care among workers and retirees, suggest that employer plans might also offer an excellent opportunity for workers to finance the expense of long-term care during their higher-income working years. The specification of such a plan, however, is likely to be critical to its acceptability to employers. Most employers who would consider adopting a plan to assist in financing long-term care may strongly resist any expansion of unfunded liability for retiree health benefits.

## Structuring Long-Term Care Insurance as an Employee Benefit

Several employers (including the federal government) have expressed interest in providing a long-term care benefit for retirees, few (perhaps only one: the state of Alaska) offer a plan to current retirees. These first long-term care plans are likely to serve as models for future plans and may affect employer and employee opinions about what constitutes appropriate long-term care coverage. To facilitate discussion about employer-provided long-term care insurance as an employee benefit, this section offers two general approaches to structuring LTC insurance on employee benefit.[2]

The primary distinction is whether the plan is "outside-funded" (capital accumulation to purchase the benefit in retirement is separate from the insurance plan) or "inside-funded" (capital accumulation occurs within the insurance plan). The definition of plan beneficiaries, the benefits covered, how benefits are triggered, and limits on coverage are factors that affect the cost of the plan and, potentially, the magnitude of potential employer liability. These details, however, are beyond the scope of this paper.

### Table 1

### RETIREE HEALTH INSURANCE BENEFITS[a]
### AMONG CURRENT ELDERLY BY FAMILY INCOME, 1984

| | All Elderly | | Elderly With Retiree Health Benefits | | |
|---|---|---|---|---|---|
| Family Income | Number (millions) | Cumulative Percent | Number (millions) | Percent Within Income Group | Cumulative Percent of All Recipients |
| Total | 26.1 | (100.0) | 6.3 | 24.1 | (100.0) |
| $0 - $9,999 | 9.2 | 35.4 | 1.3 | 13.8 | 20.3 |
| $10,000-$19,999 | 8.8 | 68.9 | 2.5 | 28.7 | 60.3 |
| $20,000-$29,999 | 4.3 | 85.2 | 1.3 | 31.7 | 81.7 |
| $30,000-$39,999 | 1.9 | 93.5 | 0.6 | 29.7 | 90.7 |
| $40,000-$49,999 | 0.8 | 95.7 | 0.3 | 34.2 | 95.2 |
| $50,00 + | 1.1 | 100.0 | 0.3 | 26.6 | 100.0 |

Source: Preliminary EBRI tabulations of the Survey of Income and Program Participation (SIPP), Waves 2 through 5 (U.S. Department of Commerce, Bureau of the Census).

[a] Includes persons age 65 or older with no earnings who reported health insurance coverage from a current or past employer at any time during the year.

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[2] This section is from Chollet and Friedland, forthcoming.

An "outside-funded" long-term care insurance plan might be an employer-sponsored capital accumulation plan (for example, a supplemental defined-contribution pension) with access to a group long-term care insurance policy at retirement. Assets to purchase long-term care in retirement would accumulate separately from the insurance plan, and the rate of asset accumulation could be independent of increases in the group plan cost. Employer and employee contributions to the cash accumulation plan, however, could be targeted to allow retirees to fully or substantially pay the projected premium. At retirement, the group insurance could be priced in at least two ways: on a "term" basis (increasing with retiree age and risk), or on an entry-age basis (reflecting the present value of the expected cost over the retiree's expected life). Purchasing a plan that is priced according toentry age is equivalent to the employee initiating an inside-funded plan at retirement.

An outside-funded plan would offer employers one primary advantage: they could avoid liability for increases in the cost of the long-term care benefit. The full indexation of retiree health liability associated with conventional retiree health plans that define benefits in terms of covered services poses a critical problem for employers that they would presumably want to avoid in devising a long-term care insurance plan. Employers may, in fact, look to an "outside-funding" approach like that described here to finance post-retirement health insurance for future retirees, if they are required to disclose and/or fund the liability accruing for their plans. Outside funding might also facilitate employers offering to retirees coordinated or alternative plans to finance acute and long-term care. Even if the employer were liable for guaranteeing access to a group long-term care plan when participating workers retired, that obligation might be met in an expanding private insurance market for long term care by negotiating an agreement with one or more insurance carriers.

An outside-funded type of plan would also offer employees some advantages. First, if such a plan were more acceptable to employers, access to long-term care coverage would be a more widespread benefit. Second, capital accumulation plans offer portability that is more difficult in other types of plans. However, such plans would place employees at risk for any short-fall between accumulated assets and the price of long-term care coverage at retirement.

Outside funding of a retiree insurance plan has little or no precedent in employee benefits, although it borrows heavily from the concept of a defined contribution pension plan or cash-deferred savings plan. However, employers who would develop a plan restricting use of distributions to payment of long-term care insurance premiums or other expenses related to long-term care may face difficulty with tax qualification, since the tax code does not now explicitly provide for restricted-use capital accumulation.

An outside-funded plan as described here would be a significant departure from employers using a 501(c)(9) trust (a voluntary employee benefit association, or VEBA) to finance a promised long-term care benefit in retirement. Despite tax code restrictions that strongly discourage employers from using VEBAs to fund retiree health insurance liability of any type, these trusts may be poorly suited to the kind of long-term care insurance benefit employers may wish to provide. VEBAs are not structured as employee-owned capital accumulation accounts: employer contributions to a VEBA are not associated with particular employees, and workers who terminate employment before retirement cannot withdraw funds from the VEBA. Although employer contributions to either a 401(h) trust (designed as subsidiary to the pension benefit) or a Section 105(h) trust (a medical expenditure account) are associated with particular workers, these trusts are not intended for employee capital accumulation either. Use of any of these trusts by employers may be best-suited to funding a defined service benefit, something that employers might wish to avoid in designing a long-term care plan for retirees.[3]

An alternative to outside-funding an employee long-term care benefit is inside-funding: offering employees a long-term care plan that offers current coverage and is entry-age priced (that is, priced at the discounted present value of expected lifetime risk). Because entry-age pricing would result in plan premiums that exceeded younger participants' immediate risk of needing long-term care services, capital would accumulate inside the plan (called inside buildup) throughout all or most of workers' pre-retirement years. At retirement, participants who had bought coverage earlier in their worklives would continue to pay the same lower premium--less than the discounted expected value of benefits after retirement. An inside-funded plan could be offered to workers at the point of retirement (as is Alaska's public employee plan); premiums, however, would be higher than if the plan were marketed to workers before retirement.

In principle, employers could offer this type of benefit either as an insured or self-funded plan, analogous to their options in financing health benefits. In practice, however, employers might find self-funding very unattractive, if it impeded their ability to alter or terminate their involvement in the plan. Employers with an insured plan might be better able to define their contributions to the premium (containing their liability for the benefit) and to negotiate continuation of coverage for workers and retirees should they wish to terminate the plan.

An inside-funded long-term care benefit would offer employees several advantages over an outside-funded plan. First, the plan would provide current coverage; although the probability of needing such coverage is low for young employees, it does have some value. Second, employees' ability to continue purchasing the plan after retirement is a surer prospect, since the price would be substantially lower for long-time participants than it would be if the coverage were initially purchased at retirement.

For workers who terminate employment before retiring, however, portability may be more difficult in an inside-funded plan, since not all employers would offer a long-term care insurance plan or offer the same plan. However, portability might be facilitated by allowing terminated employees the option to buy into the plan or to buy conversion coverage from the same or another insurance carrier.

Similar to an outside-funded plan, inside-funded plans might face some difficulties in obtaining tax qualification, simply because there is no precedent for employer-sponsored long-term care insurance benefits. Although current law would allow employers to deduct premium payments, employer contributions and/or plan distributions could be taxable as personal income if coverage included substantial nonmedical, personal care services.

Employees' rights to the plan's inside buildup in the event of bankruptcy reorganization or merger might also be difficult to resolve; this is not now an issue for retiree health plans, since benefits are almost universally financed pay-as-you-go. In the event of insurer bankruptcy, employers might still be liable for providing long-term care insurance coverage, or for paying claims incurred but not paid by the insurance plan.

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[3] At least one employer has used Section 105(h) based on an IRS letter ruling to establish a tax-exempt "medical expenditure account" to finance health insurance benefits for current workers and retirees. While 105(h) plans have not been used widely or at all to fund accrued liability for future benefits, employee benefit consultants have suggested that these plans may be useful for that purpose since unused balances can be rolled over to subsequent years--a feature that is obviously critical to capital accumulation. However, 105(h) accounts may be poorly suited for funding benefits which may not be paid for a substantial number of years, since employer contributions cannot be deducted as a business expense until distributions are made from the account in payment of participants' health care bills.

## The Potential for Long-Term Care Insurance as an Employee Benefit

The potential for achieving widespread long-term care insurance coverage among future elderly is a strong argument for fostering long-term care as an employee benefit. Long-term care coverage among retirees that would be as common as pension benefits or employer-sponsored health insurance would represent a substantial improvement on the current holding of such coverage among the elderly and might substantially exceed the coverage that could be achieved by individual purchases.

There are a number of competing factors that make the likelihood of achieving this potential uncertain. A potential barrier is employer concern over the unfunded and accruing liability of post-retirement medical benefits. Another is the feasibility for employers and employees to consider restructuring employee compensation packages to include long-term care insurance. It is assumed that unless there are changes in productivity, employers are not likely to add additional benefits; nor are they likely to consider programs that might increase financial liability.

The cost of paying for promises of health care can be staggering. Many firms offering post-retirement medical benefits to current retirees, have not prefunded and may have an unfunded liability in excess of the value of the firm's assets. The Department of Labor estimated that based on the workforce age 40 or older in 1983, the unfunded liability was $98.1 billion. Firms are likely to seek ways to either avoid increasing their unfunded liability or reduce the continuation of accruing liabilities for retiree benefits.

Microsimulation projections of pension recipiency among future retirees indicates that both the proportion of elderly receiving pension benefits and the average real income provided by pensions may grow, even if pension coverage rates among current workers remain the same. (Chollet, 1987; Andrews and Chollet, 1987). This suggests that employers and workers may have some latitude in restructuring retirement benefits toward insurance benefits without jeopardizing current levels of retirement income.

Even assuming that within-industry pension plan coverage rates among workers show no growth over a forty-year simulation period, future retirees are more likely to have income from a pension plan than current retirees, and to have higher average real pension income than today's recipients (see Table 2). In part, this trend can be explained by the longer tenure of young workers in a post-ERISA workforce, compared to workers now retiring. Most of this growth, however, results from the greater opportunity of young workers to vest in several defined contribution pension plans and from increase in the labor force participation of women. (The microsimulation results presented here assume continuation of the longer defined-benefit vesting standards allowed before tax reform and, as a result, may understate eventual defined-contribution pension income among future retirees.)

In 1985 dollars, average pension income among married-couple retirees in the youngest cohort simulated with pensions is expected to rise more than 83 percent, to $13,000 compared with $7,100 among couples retiring today. Among single retirees, average pension income is projected to rise at a somewhat slower rate, from $5,300 among single workers now retiring to $9,000 among the youngest cohort of single retirees.

The prevalence and income distribution of retirees with employer-sponsored pension and health insurance benefits is a favorable indication of the potential for employer-sponsored long-term care insurance. If employer-sponsored long-term care insurance had emerged parallel with retiree health benefits supplemental to an employer pension, perhaps 19 percent to 24 percent of today's elderly may have had access to long-term care coverage in retirement--including many low-income retirees.[4]

Projections of future pension recipiency suggest the potential for the development of long-term care insurance as an employer sponsored benefit. However, the current political climate may not be well suited for these changes. Recent tax reform has broadened the tax base and lowered the marginal tax rate. Tax base broadening has already limited retirement income savings, suggesting that the legislative process might not be inclined to either extend or necessarily maintain tax preferences for current or retiree benefits. Lower marginal tax rates may lower employee incentives for more deferred nonwage compensation, especially if real income of the nonelderly continues to decline.

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[4] Estimate is based on preliminary tabulations of retirees with employee-provided health benefits in the Survey of Income and Program Participation (waves 2 through 5). For more discussion on this observation please see Chollet and Friedland, Forthcoming.

Preferences among employees for more deferred nonwage compensation could develop, however, as the baby-boom ages and the average age of the labor force rises. Changing demographics could bring about a new focus on retirement benefits that would not have occurred otherwise. This may be exacerbated as more individuals experience providing chronic care to their parents and grandparents.

Table 2

PERCENT OF FUTURE RETIREE FAMILIES
WITH PENSION INCOME AT AGE 67
AND AVERAGE PENSION INCOME IN CONSTANT 1985 DOLLARS:
MICROSIMULATION PROJECTIONS BY 1979 AGE COHORT[a]

| | 1979 Age Cohort | | | |
|---|---|---|---|---|
| | 25-34 | 35-44 | 45-54 | 55-64 |
| Percent with pension income | 63 | 61 | 57 | 48 |
| Average income among recipients (dollars in thousands): | | | | |
| Married couples | | | | |
| Total | $ 13.0 | $ 10.4 | $ 8.8 | $ 7.1 |
| Defined benefit pension | 9.0 | 7.9 | 7.1 | 6.5 |
| Defined contribution pension | 9.9 | 7.9 | 6.1 | 4.4 |
| Single individuals | | | | |
| Total | 9.0 | 6.8 | 6.9 | 5.3 |
| Defined benefit pension | 7.2 | 6.0 | 5.6 | 5.1 |
| Defined contribution pension | 6.9 | 5.1 | 4.8 | 3.3 |

Source: Employee Benefit Research Institute. - Preliminary results from the Pension and Retirement Income Simulation Model (PRISM) (See Chollet, 1987).

[a] A description of the base-case PRISM assumptions underlying these microsimulation results appears in: Kennel and Shiels, 1986.

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## STATEMENT OF THE NATIONAL ASSOCIATION OF MEDICAL DIRECTORS OF RESPIRATORY CARE

The National Association of Medical Directors of Respiratory Care (NAMDRC) is a professional organization composed of physicians who serve as medical directors of respiratory care programs in over 2000 hospitals nationwide. Eightyfive percent of our membership is composed of internists and pulmonologists, and anesthesiologists account for 12% of our members.

NAMDRC supports the goal of catastrophic health insurance and, as many others, we see it as but one step toward addressing the complex issues surrounding long term care. The proposed approach of expanding the acute care benefits for Medicare beneficiaries is encouraging and we support it. Likewise, NAMDRC views the proposed payment methodology, a modest increase in the Part B premium, as a logical approach to fund the program through contributions of those most likely to benefit from it.

NAMDRC does have, however, one serious reservation about the program as we understand its likely implementation. If indeed the Congress hopes to expand the beneficiary's length of hospital stay from the current maximum of 150 days to 365 days, and if the payment mechanism for such an approach is a simple expansion of outlier payments, we fear that such a plan will not come close to meeting the costs that hospitals will incur.

NAMDRC began detailed research on this subject nearly two years ago when we attempted to examine the variable costs of maintaining ventilator patients in the hospital for extended periods of time. These results have been published under the title "Financial Implications of Prolonged Ventilator Care of Medicare Patients under the Prospective Payment System" in the March, 1987 issue of Chest, published by the American College of Chest Physicians.

A brief review of the data shows that Medicare beneficiaries who were mechanically ventilated for at least 48 hours incurred hospital costs significantly beyond reimbursement. These costs, averaging over $21,000 beyond Medicare reimbursement, far outweighed any amount that a hospital could have received for so called low-end DRGs. Therefore, it is clear that hospitals have a financial incentive not to use a particular life sustaining technology.

There is growing recognition by health policymakers from the Congress and the Administration that the outlier program does not adequately reimburse for intensity of care. A plan to expand such an inadequate program only exacerbates a problem rather than solving it.

As a solution, NAMDRC strongly urges Congress to address the issue of intensity of care prior to any significant expansion of the outlier program. We also suggest two possible solutions that could be used to address the intensity of care problem concerning patients who require mechanical ventilation for 48 hours or longer:

1. Establish a multiplier factor for this group of patients. Use it to multiply the DRG payment by the specified amount. For example, let's say that mechanically ventilated patients historically have costs eight times beyond those of non-ventilated patients. Reimbursement for these patients would be calculated by multiplying the appropriate DRG payment by eight.

   The need for mechanical ventilation is well accepted within defined medical criteria, so that the chance of abuse beyond these criteria is slim. With a little effort PROs could have solid review criteria for such cases which, legitimately, should undergo initial review.

2. Establish a new DRG. The current system simply does not adequately address the costs incurred by a hospital when a Medicare beneficiary is mechanically ventilated for 48 hours or longer.

All patients who require mechanical ventilation for 48 hours or longer would be transferred to this new DRG regardless of the principal diagnosis and the relative weight of this new DRG should reflect the costs of the resources used with these patients. HCFA should have the cost data available to move in this direction.

Again, NAMDRC commends the Committee for addressing catastrophic health costs. We simply urge you to act wisely and prudently, and most certainly request that you not discriminate against those patients who are most likely to incur catastrophic costs.

# STATE AND LOCAL GOVERNMENT INVOLVEMENT IN REVERSE MORTGAGE LENDING: OPTIONS AND EVIDENCE

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## I. Introduction

Home equity conversion (HEC) for the elderly is a comprehensive phrase for programs, plans, and financial instruments designed and intended for elderly homeowners to draw a cash flow from their home equity. In the U.S. a great deal of HEC takes place regularly through formal and informal arrangements such as property tax deferral programs for the elderly and gifts and loans from children to their aged parents (where the transfer is done with a contemplation of deferred repayment based on the home equity). Further examples are shown as Exhibit 1.

The newest and perhaps most controversial form of HEC is that based on financial instruments dedicated to the concept. Such dedicated instruments include reverse mortgages and residential sale-leasebacks. This paper is focused on reverse mortgages (RMs).

An RM loan is a loan that explicitly looks to home equity as security or collateral. Generally, RMs have a regularly scheduled flow of funds from lender (mortgagee) to borrower (mortgagor). The pattern of the flow of funds is the reverse of a normal home mortgage loan. RMs were offered off and on during the 1970s on a casual basis, but since 1981 there have been a number of private and public programs with a major emphasis on this type of lending.

The public programs (many of which use private lenders for funding and servicing loans) have originated approximately 400 RMs. The principal private program, IRMA, was begun by American Homestead Mortgage Corporation and it also has originated approximately 400 RMs. The main differences between this private plan and public RMs have been that the IRMA loan plan has no meaningful limit to the number of disbursements that will be made and has a shared appreciation feature, while the public based programs have had fixed interest rates and no promise of continued disbursements beyond a scheduled term of maturity. Indeed, most public based RMs have a scheduled repayment date that coincides with the cessation of loan disbursements.[1]

The involvement of governments and public agencies in any activity that takes place in the private sector is inherently controversial. If the private market can generate the activity, then why should the public sector interfere? This is a fair question to ask with respect to RM lending. Very briefly one can cite five reasons for public sector involvement: first, private sector activity has been sporatic and typically short-lived; second, the costs (or expected costs) to homeowners of private plans have been high; third, there is a social interest in allowing elderly homeowners to remain in their homes when they wish to do so; fourth, maintaining elderly people in their homes may be less expensive to government than available alternatives; and finally, there is reason to believe that like many public programs from social security to mortgage insurance, a successful public demonstration will generate private activity.

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[1] These data are for RM lending in the United States. In England life insurance companies make reverse annuity mortgages, with considerably different effect. There have been over 15,000 RAMs written in England. The reason for the very large British experience lies in favorable tax treatment of the transaction. In other words, the public sector is involved through "tax expenditures."

Exhibit 1
Different Types of HEC Arrangements

| restrictions | informal (no program) | formal program |
|---|---|---|
| tied to purchase of good or service | second mortgages for specific purposes | property tax deferral, deferred payment loans |
| general eligibility conditions | loans from children to parents | RAM Program, CHFA Program, H.E.L.P. |
| no tie or conditions | home equity loans, trading down to less expensive home | IRMA (American Homestead Mortgage Corporation) |

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II. How might state and local governments and agencies become involved?

Governments and agencies already have become involved in RM lending, but in this section the more comprehensive question of potential involvement is addressed. In the third section the actual involvement will be reviewed.

Public RM involvement could take place directly or indirectly, with the financing, origination, or servicing of loans, or with the provision of technical expertise, counseling, and advising. This opens up a wide range of possibilities, but the most plausible types of involvement are not so numerous.

Direct or indirect involvement. Public agencies can participate in an activity by performing a service or by assisting another entity. The public sector can, for example, generate and sell electricity, or become involved at a remove, such as by regulating the generation, transmission, and sale of power, or by offering income assistance to purchasers of power, or by purchasing the debt of utility companies.

It is generally believed that in a market economy the direct provision of a good or service by a public agency should not be undertaken without a compelling reason. This position is predicated on the belief that private organizations tend to perform tasks most efficiently because of the incentive to minimize cost. If public agencies are to be directly involved in HEC, it should be because there is reason to believe they can perform their task better or because no one else would.

The case for indirect involvement is simpler. If the public sector wants to encourage HEC, it can always do so by assisting the process -- short of directly becoming involved.

Direct involvement could take the following forms:

- making, funding and/or servicing RMs;
- purchasing loans originated by others;
- subsidizing the interest rate on private RMs;
- providing independent counseling and information to homeowners;
- insuring or guaranteeing some aspect of RMs.

Indirect involvement could take the following forms:

- offering technical advice to lenders;
- marketing and public education;
- providing an appraisal of private programs (seal of approval);
- creating a legal and/or regulatory environment favorable to HEC;
- coordinating other public programs with RM lending (such as by channeling private HEC funds to purchase specific services).

The different types of potential public involvement are substantial in number, and in fact are even more numerous in that many cross-combinations could exist. There are a few types of involvement, though, that are most promising and bear more discussion.

The easiest way for the public sector to become involved in RM lending is by becoming the lender. A public agency can provide a substantial amount of HEC without necessarily having to put out a large sum of money. The reasons for this are HEC leverage and the possibility of tied loans.

HEC leverage refers to the facts that: (1) most term RMs do not run to the stated maturity of the agreement, and even non-term RMs will have realized maturities less than the life expectancies of the borrower(s); (2) the total disbursements on any loan are always considerably less than the total repaid (see Exhibit 2); (3) the longer the realized term of a loan, the smaller the ratio of disbursements to repayment (see Exhibit 2); (4) in an on-going RM program a steady state of cash flow should be reached fairly quickly and once this equilibrium is reached essentially no new funds are required to finance a continuing program. This final point bears a little explication.

The easiest way to follow the argument is to assume that a lender commits to make a certain dollar volume of disbursements per year. Given property values, interest rates and terms to maturity, the commitment translates to an initial quantity of RMs. As already noted, the evidence on term RMs is that many loans are paid off within the first few years of the loan life. This is due to a variety of factors, but the most important are that elderly homeowners who are interested in HEC tend to have serious medical and/or financial problems, and it is not unusual for these problems to result in a death or a moveout within a few years. For these homeowners the RM is a palliative, not a panacea. The result of the early payoff is a shorter term for most RMs, with a few continuing for a relatively long term.

Exhibit 2

End of Year Loan Balance and Amount of Funds Extended:

Term Reverse Mortgage

fixed interest rate: 10%
term: 10 years
final loan balance: $100,000
monthly payments: $484.14

| End of Year | Funds Disbursed | Loan Balance | Disbursements/ Balance |
|---|---|---|---|
| 1 | $5,810 | $6,134 | 94.7% |
| 2 | 11,619 | 12,911 | 90.0 |
| 3 | 17,429 | 20,397 | 85.4 |
| 4 | 23,239 | 28,667 | 81.1 |
| 5 | 29,048 | 37,803 | 76.8 |
| 6 | 34,858 | 47,895 | 72.8 |
| 7 | 40,668 | 59,045 | 68.9 |
| 8 | 46,477 | 71,362 | 65.1 |
| 9 | 52,287 | 84,968 | 61.5 |
| 10 | 58,097 | 100,000 | 58.1 |

As soon as loans begin to be repaid, the lender is relieved of its commitment to pay out a certain number of dollars per year. The repayments substitute for new funds from the lender. New loans can be made to replace the repaid RMs. Indeed, if the original loans are repaid with interest the number of loans that can be carried will grow. If there is a constant pace of repayment, in time a steady state of repayment and relending will be reached. An increasing number of same sized new loans can be made regularly with no new funding.[2]

Even if loans do not have a quick payoff experience, the tendency of repayments to level off will be exhibited. The rate of repayment will determine when the leveling off or steady state is achieved. The annual quantity of new loans will of course be higher the shorter the realized term of the RMs.

A second potential factor that would allow a public agency to do substantial RM lending without a very large extension of funds would be tied loans. If the funds generated by the RMs are designated to be used in a specific way, and these funds replace some portion of funds that would have been spent by the government sector (even if not the very same agency), less will be advanced on net than with an unrestricted loan. In fact, because the tied loan would be a substitution of private for public funds, the long term effect on the public sector would be to reduce its overall outlay. Without delving into the matter further, it is sufficient to cite the examples of home repair and medical care.

A second form of public sector involvement is the purchase of RMs originated by other (presumably private sector) institutions. The lending function should be seen as a trifold set of functions: loan origination, loan servicing, and loan funding. The origination and servicing functions are administrative activities. The funding of a loan is the providing of money. It has become common to view funding as a separate activity in the forward (or regular) mortgage markets. This has been encouraged in the public sector by quasi-governmental agencies such as FNMA or the FHLMC.

A third type of potential direct involvement is the insurance or guarantee of RMs. The parallel example in the forward mortgage market is the existence and function of the Federal Housing Administration. An FHA guarantee provides security to the lender that the loan will be fully repaid. Since forward mortgages are amortizing loans the guarantee is most important in the earliest years of the loan when the borrower's equity is typically the smallest -- before much repayment of principal has occured or property appreciation taken place. The FHA guarantee stays with a mortgage, even if it is sold or resold.

An RM guarantee program would also protect the mortgagee against insufficient repayment of a loan balance. The factors associated with RM loan default would be different than with forward mortgage default, as would the variables determining the insurer's exposure. Forward mortgage insurance is riskier in that all loans pass through a window of high loan to value ratio while few RM loans will reach a high ratio, but RM insurance is riskier in that the loans are non-amortizing so that if a loan reaches a high LTV ratio there is a very small cushion of equity.

The last form of direct involvement to be mentioned is the subsidization of RM interest rates. Apart from the question of whether public entities can borrow at below market interest rates after 1987, one can ask whether some loans should be subsidized. The answer is that we already observe very large volumes of direct subsidies and tax expenditures. One need only mention farms and farming, student loans, and property tax exemptions, to point out examples of the pervassive system of subsidies and tax expenditures currently in place. It is not a question of whether the economy will tolerate subsidies but rather which subsidies are in the public interest.

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[2] This assumes no administrative costs. Additionally, the argument is only tight in a non-inflationary atmosphere. If there is inflation the average loan size would grow and the number of loans that could be made would depend on the relationship of property appreciation to the interest rate charge.

The forms of indirect public involvement with RM lending are straightforward. Some of the items listed above would be complements to direct involvement while some could be provided without direct involvement. An example of a complementary activity would be public marketing and education. Other forms of indirect involvement would be reasonable substitutes for direct involvement, as for example the creation of an hospitable legal and regulatory climate.

In sum, there are a wide variety of ways that public entities can become involved with RM lending. The different types of involvement would carry different magnitudes of commitment, start-up costs, continuing effort, budgetary implications, and different obligations for the future. The desirability of becoming involved with HEC must be balanced against the reality of a commitment. If a public agency wishes to foster and encourage HEC it can be done at many different levels. The consequences of the effort will differ substantially: a willingness to become directly involved by making or guaranteeing loans will have a much stronger impact than a willingness to talk with lenders and advise them if advice is sought.

A matter of consideration in beginning an HEC effort is what might best be called pathbreaking. Some types of involvement have predecessors, others would require development of a concept. Clearly, the types of activity that have already been undertaken or planned, make replication by another agency easier. It is simpler to base an effort on the experience of someone else than to begin afresh. It is in this light that attention will now be shifted to examples of current public HEC involvement with RM lending.

## III. State government or agency reverse mortgage activity.

State and local governments are currently directly and indirectly involved with HEC. There are four major categories of this HEC activity. The City of Buffalo developed and the Arkansas Development Finance Authority replicated a program of split equity transactions with older homeowners. Both of these programs are known as Home Equity Living Plans. Second, some municipalities and county governments have been actively involved in RM lending as counselors to homeowners. Third, the Florida State Legislature enacted legislation directing the Florida Housing Finance Agency to develop a program for the establishment of a Guaranty Fund for reverse mortgages. The authority and responsibility for this program was subsequently transferred to the Florida State Treasury. Fourth, the State of Connecticut has an RM program in place in which the Department on Aging provides counseling and the Connecticut Housing Finance Authority makes RM loans. The Rhode Island Housing and Mortgage Finance Corporation has recently begun an RM lending program that is similar in a number of respects to the Connecticut program.

The Connecticut and Florida activities are of particular interest as they carry the possibility of substantial and significant contribution to the way HEC will be carried on in the future. The first program to be discussed will be the Connecticut program, and that will be followed by a discussion of the Florida Guaranty Fund.

During 1983 and 1984, a task force empaneled by the Governor of the State of Connecticut met to discuss and formulate a program for HEC. An outgrowth of the deliberations of the task force was a pilot RM lending program. The pilot program is administered and funded by the Connecticut Housing Finance Authority (CHFA), with cooperation and assistance of the Connecticut Department on Aging.

The Pilot Reverse Annuity Mortgage Program is an RM program for older homeowners. The first loans were closed in July, 1985, and as of mid-November, 1986, 114 loans have been closed. There have been three "rounds" of the program. In each round a specific sum of money has been designated for the funding of RM loans. Additionally, with each round there have been modifications to the program -- either to the instrument or to eligibility rules. The following descriptions are for the program and instrument as currently operating in round III.

Administrative responsibility is shared in the Connecticut reverse mortgage program (CRMP). The initial responsibility is with the Department on Aging. Homeowners seeking information on HEC are instructed to contact the Department. The Department provides general counseling to elderly homeowners and their representatives, supplying them with information on all HEC programs that are operating in the state and for which the homeowner is eligible. (There is an optional service of volunteer counseling coordinated by the Department. This service is little utilized by homeowners.) If the homeowner is eligible for and interested in applying for a loan from the CRMP, an application is taken by a CHFA representative. If applications exceed the sum of money designated for a given round, the Department on Aging would be responsible to conduct a drawing or lottery to select participants for the program. Thus far, however, the quantity of applications has not exceeded earmarked funds.

The CHFA in essence takes over responsibility after the preliminary screening by the Department on Aging. CHFA is the agency responsible for closing, servicing and funding. It has the major executive responsibility for the program and the initial instrument design and subsequent modification have been done by it.

The CRMP loan has the following characteristics.

loan term: 10 years.

interest rate: fixed and below market. Current rate is 7%.

regular disbursements: monthly disbursements. Payments graduate by 3% annually during the term of the loan.

initial disbursement: an initial disbursement of no more than $5,000 may be made for three purposes;

1. to clear liens,
2. repairs or improvements to home,
3. medical expenses.

fees: fees are financed as part of the loan.

| | |
|---|---|
| loan origination fee | $200 |
| legal fee & recording costs | 300 |
| appraisal | 150 |
| title search & title insurance | 150 |

The program has eligibility and other restrictions. The following are the major limits for the program.

income: family income may not exceed 50% of county median (where county median is unrelated to age or marital status)

borrower: single or co-borrower, each of whom must be 65 or older.

property: no limit on property value but property must be free of liens (after the use of any initial disbursement). Therefore the maximum debt against the property at application could not exceed $5,000. The home must be in Connecticut and either a single family, condominium, or a two, three or four family house with owner occupant.

loan balance: maximum of $80,000 or 80 percent of appraised value, whichever is smaller.

Taking into account the preceding description, the CHFA RM is not particularly distinct from other term RMs -- the only characteristics worth comment would be the mandatory 10 year term, the below market interest rate, and the mild rate of payment graduation. There is, however, one characteristic of the CHFA RM that is unique. At the end of the scheduled payments (i.e. at the end of the 10th year), if the borrower is still an occupant in the home, continued occupancy is guaranteed for as long as the borrower is willing and able to remain in the home. If there has been sufficient property appreciation the disbursements can be continued as well. There would be no repayment requirement, of principal, accrued interest, or continuing interest. Hence, the CHFA RM is in the nature of a guaranteed or insured loan.

It should be emphasized hat the guarantee of the CHFA RM is unlike an annuity or insuranc product. The principal differences relate to the type of guarantee (occupancy and not payments), the absence of any premium, and the consequent absence of true risk pooling. The combination of the same fixed term for all borrowers with the same disbursement per dollar of home equity is that which belies the creation of (an implicit) risk pool. This may be seen most clearly with a counter-example.

Suppose the CHFA RM was unchanged except for a disbursement schedule tied to age. Older homeowners would receive a larger monthly disbursement per dollar of equity than younger. The program could still have a ten year term for all borrowers, but the loan balance at the end of 10 years would be different for borrowers of different age. However, the loan balance at the expected term of the loan, which would be determined by death or moveout, would be the same for all loans.

If one extends the idea a tiny bit, a recognizable insured product would be evident. If the lender holds back an amount from each regular disbursement and reserves it, or adds an initial charge to the loan and reserves it, the RM would be an explicitly insured instrument with a risk pool. Borrowers who remain in their homes for a short time would be contributors to the reserve fund, and borrowers who remain for a long period (and whose homes fail to appreciate sufficiently to keep ahead of the loan balance) would draw from the fund.

Program activity. As of mid-November, 1986, there have been a total of 198 applicants to the CRMP. Of this number, 114 resulted in loan closings, and a number of the applications are still open. For example, in the third round of the program, of 73 applicants, 10 officially withdrew, 40 have completed their applications and are receiving disbursements, and 23 applicantions are in progress or inactive. Summary statistics on the full 114 closed loans are shown in Exhibit 3.

Data have also been collected on other reverse mortgage programs, in other parts of the country. One program that provides an interesting comparison is operated in Nassau County, New York. In that program the RM entails no occupancy guarantee and loan term is chosen by the borrower. Because there is no occupancy guarantee, homeowners tend to choose shorter terms to maturity. The average term in the New York program is 6.5 years. Other interesting comparisons are to be seen in a higher Nassau

Exhibit 3
Summary Statistics from Connecticut Reverse Mortgage Program
Completed Loans
as of November, 1986

| | |
|---|---|
| Total Loans Closed: | 114 |
| Average Property Value: | $109,689 |
| Average Loan Balance: | $59,307 |
| Average Monthly Disbursement: | $328 |
| Average Age | |
| Married Males | 75.3 |
| Married Females | 71.5 |
| Single Males | 74.9 |
| Single Females | 75.0 |
| Percent Married | 23.7% |
| Percent Single Males | 12.3% |
| Percent Single Females | 64.0% |
| Average Income, Couples | $13,444 |
| Average Income, Singles | $9,073 |

County property value ($171,895), and a higher average age of single homeowners (80 for males, 78 for females).

The CRMP is a program that has been successful on a number of grounds. It has seen the development of a coordinated interagency relationship, it has grown very quickly from design to action, it has created a new RM instrument with desirable guarantees, it has evolved over its one and a half year active life with improvements to its loan instrument, and it has provided income from home equity for over one hundred elderly households. There are other modest and radical changes to the program that can be proposed (see section IV), but no proposals for improvement should push aside the success of the program nor the ingenuity of its sponsors.

The second program to be discussed is that of the State of Florida. Before describing the Florida program it is relevant to look at its background in comparison with that of the CRMP.

The Connecticut program came into existence out of the deliberations of a task force and the design efforts of those who would subsequently implement it. The Florida program was created in the State Legislature, and those who would be asked to implement it were brought in later. The CRMP can be described as a reverse mortgage with a special feature -- the occupancy guarantee. The Florida plan is a more substantial break with existing instruments and procedures. Lastly, the CRMP involves funding from within the CHFA both for administration of the program and for disbursements. The Florida plan has been completely dependent on the Legislature for funds for the implementation of the program.

The CRMP is an active program. The Florida plan has not moved beyond the design phase.

The Florida plan was created with the Florida Home Equity Conversion Act (Sec. 697.20-697.206 of the Florida Statutes). The Act creates a Home Equity Conversion Mortgage Guaranty Fund, the purpose of which is to insure lenders against borrower default on a reverse mortgage. As originally enacted, the Guaranty Fund would cover the difference between (1) the RM loan balance at loan termination, and (2) the sum of proceeds from a foreclosure sale and any personal or real property of the judgement debtor recovered from the judgement debtor.

A few comments are in order on the original design. The Fund would only be involved in a loan payoff in cases where there was a deficiency between loan balance and property value, and there were little or no other assets of the mortgagor. Second, the RM loans to be insured in this program would be term loans. There would be no guarantee that the homeowner could remain in the home beyond the term of the mortgage. Indeed, the nature of the guarantee was that the homeowner would have to be foreclosed upon for the Fund to be drawn down. The term of insured loans was specified in the Act to be life expectancy plus one year, or if more than one mortgagor the life expectancy of the younger mortgagor plus one year. The Act did not mention how interest rates would be determined (or what a permissible rate would be, other than either fixed or variable), nor whether there would be any limit to loan size, size of disbursements, or property value.

Improvements have been made on the original design of the HEC Mortgage Guaranty Fund, but the implementation of the Fund seems no closer to reality today than three years ago. The Legislature has not appropriated funds for the operation of the plan. Major responsibility for the Fund has been transferred from the FHFA to the Florida State Treasury. Until funds are appropriated for operations, the plan will not go forward.

The idea behind the HEC Mortgage Guaranty Fund is that of risk pooling. Attached as an appendix is an executive summary to a study: A Loan Loss Reserve for Florida: Alternative Models to Guaranty Reverse Mortgages. As the study indicates, it is possible to design a premium structure for this type of Guaranty Fund by focusing on the risk pool or reserve fund. The crucial matters are what is to be insured, and what type of loss sharing arrangement (between insurer and lender) is to be in effect.

A state government agency is an ideal sponsor for an RM Guaranty Fund. It can establish a limit to the number of RMs it will insure, it can limit its loss per loan, and even limit the size of the loans it will insure. In setting the premium schedule, the agency can design a schedule that (in combination with permissible terms to maturity) is expected to break even. If the experience of the loans turns out to be unfavorable, a state agency can at least tolerate a loss. In addition, the agency can put restrictions on the loans to be insured so that they are targeted to housholds deemed to be in need of assistance. In short, an agency can put socially desirable limits on eligibility and on the instrument.

Developing an insurance or guaranty fund through a state agency is of special importance because it need not make a profit to stay in existence until the last loan is repaid, and because such a structure simplifies the licensing/regulatory process. Most private insurers have specific regulations that confine their set of permissible activities and that consequently discourage innovation. It is much easier to develop the model for RM insurance outside the traditional regulatory framework, and then once the model exists, restructure laws and regulations specifically to permit the desired activity.

## IV. Possible variations on the CRMP.

The Connecticut program, as described in section III, provides period certain income and temporally unlimited occupancy to older Connecticut homeowners. These principles have not changed over the life of the program and are unlikely to change in the foreseeable future. There are some interesting variations, however, that either the CHFA or other state agencies might be interested in investigating.

### 1. Eligibility and emphasis.

The CRMP has changed its eligibility limitations during the course of its operations. All changes have been in the direction of liberalizing eligibility -- i.e. of increasing the number of eligible homeowners. It is possible to change eligibility requirements in such a way as to target specific households. This could include focusing on frail elderly, medically needy, or those in specific geographic areas.

The targeting might also involve coordination with home repair plans or other housing related assistance, such as maintenance packages, or landscaping, or snow removal. RMs could be used to provide specific additional services to the elderly that are particularly associated with homeownership. By doing this, as opposed to replacing other types of public assistance (e.g. food stamps), homeowners would be paying for services that are not being provided by the public to non-homeowners at no or at below market cost.

### 2. Funding.

The CRMP is exclusively funded by CHFA reserves. This is an imaginative and productive use of such reserves. There are other public reserves and trust funds that might be used in a similar way.

Beyond the matter of the use of reserves, it might be desirable for other agencies to pick up the funding of an RM program from their own funds, or through the issuance of debt. One agency could fund, another could administer the program. This would make particularly good sense if there was an immediate benefit to an agency of a lower outlay on other programs.

RMs need not be viewed as different from other kinds of loans by government entities. Student loans, for example, are funded through the issuance of secondary market paper. This could be done with RMs, with superior collateral.

### 3. Disbursements.

RMs that have been offered in organized programs have had scheduled disbursements. A common complaint of elderly homeowners considering HEC is that the schedule of disbursements does not match their needs. An instrument could easily be designed that allows for flexible disbursements.

A flexible disbursement RM would be similar to a line of credit, but unlike the conventional line of credit it would not require out of pocket repayment. That would be deferred until some condition was reached. This type of loan could have annual (and even monthly) restrictions on size of disbursements in order to keep the rate of growth and the size of the loan balance to acceptable limits.

A related instrument would be a one time loan, without immediate amortization. This would be analogous to the initial disbursement on a CRMP type of loan, but with a much higher limit. For example, under the current CRMP, the maximum loan balance of $80,000 in 10 years is reached with a monthly payment that begins at $402 (and graduates by 3 percent annually). If the current maximum initial disbursement of $5,000 is taken down, the initial monthly payment drops to $352. With the current 7 percent interest rate an initial disbursement of $39,808 and no monthly payments would reach $80,000 at the end of 10 years. Presumably, the risk borne by the lender on the two instruments is similar.

4. Age, disbursements, and guarantees.

As already noted, the use of the same term to maturity for all households, regardless of age or marital status, opens the lender up to risk and adverse selection.[3] This is supported in the Connecticut data by the younger average age than in other RM programs. If disbursements were tied to age and marital status, the risk associated with loans to younger households would be reduced.

The importance of age and disbursements derives from the occupancy guarantee. A closely related issue is the nature or form of that guarantee. In the simple term RM there is no guarantee of anything beyond term. In the CRMP the guarantee is that the household can remain in the home beyond term (provided they wish to and are able to do so). To take the matter one step further, disbursements could be guaranteed to continue beyond "term" -- that is, guaranteed for occupancy. This would obviously expose the lender to more risk only if the size of the disbursements were unchanged from those prevailing with the present type of guarantee, and if they were unrelated to age or marital status.

If the size of regular disbursements were tied to expected occupancy (for which age and marital status are determinants), the lender would in effect be creating a risk pool. The rate of return to the lender on RMs whose actual terms are shorter than expected (on average) would be larger than those whose terms were longer than expected.[4] The rate of return on all loans together (i.e. "the pool") would be an average of the individual rates of return.

5. Explicit insurance.

The insurance aspect of the loans discussed in section 4 is implicit because no insurance premium is included. The implicit insurance is there if one adjusts the loan interest rate to produce an expected rate of return which is acceptable to the lender. If this is taken one step further, an insurance premium could be charged.

The advantage of the existence of a premium is that it allows the directors of a program to decide who should pay for the insurance and how that payment should be related to occupancy. The premium could be a one time up-front charge to all borrowers, a monthly charge, or even in theory a one time charge at loan repayment. Different premium structures imply different budens of the plan.

6. Interest rates.

Interest rates in all of the RM programs with a public sector tie have been fixed. There is little doubt that fixed rates are more popular to consumers than are variable rates, not only for RMs but for forward mortgages as well. This is not to say, though, that any and all consideration of a variable interest rate should be forsaken.

An RM loan represents an obligation to disburse funds at a future date. In virtually no instances are private lenders willing to obligate themselves to disburse funds at points well into the future at an interest rate decided upon in advance. If

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[3] It also prevents borrowers from using an RM for short term, high disbursement, purposes.

[4] If property appreciation is substantial, then all loans would be repaid in full and the rate of return on all loans would be equal to the interest rate.

RM lending is intended to have a sound financial footing, either variable interest rates must be considered or a scheme must be arranged so that funds for futue disbursements can be locked in at loan origination. One simple way for this to be done is to set aside funds at loan origination that are equal to the expected present value of disbursements over the life of the loan. An example may be helpful.

Suppose an RM has an obligation of monthly disbursements of $420 per month for 12 years. The 12 years is the obligation of the lender, but the expected period of disbursements is shorter than that. Let the expected number of disbursements be 72. The present value of the 72 expected disbursements at a 7 percent discount rate (roughly the intermediate term rate on riskless funds) is $24,779, or $5,461 less than the sum of the expected disbursements (not discounted). If the lender were to set aside $24,779 before disbursements began, at the end of the 72nd month all earmarked funds would be exhausted.

As always, such funding calculations would be best done for a pool of loans, to allow for offsetting risks. For a lender with substantial cash reserves (such as a state HFA), this type of funding arrangement is appealing.

## V. Conclusion.

This completes the review of arguments for and mechanisms for public agency involvement in reverse mortgage lending. The experience of RM lending to date in the U.S. seems to indicate that there is skepticism on the part of elderly homeowners directed at anyone who would offer to lend them money on their home equity. This reluctance to enter into HEC contracts is healthy.

By the same token, the inability of elderly homeowners to enter into an arrangement that would allow them to use their largest and perhaps only asset is unfair. In an economy that relies on the market for the exchange of virtually all goods and services, it is inconsistant not to allow the conversion of home equity to income. State agencies can play a special role in fostering this kind of opportunity while at the same time ensuring that it is done with adequate consumer safeguards.

It is hoped that this background paper will stimulate thought, discussion, and implementation.